

Lands



phoenix Rising

THE VOICE OF THE PSYCHIATRIZED

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Serenace
Equanil
Tolnate
Surmontil
Nembutal
Fenzol

Pills sometimes but more often as a liquid so they could make sure I really swallowed it. And whenever I did something that was bad they'd throw me down and give me a shot that put me out for the rest of the day.

and others I had to take without even knowing their names.

WOMEN AND PSYCHIATRY

PHOENIX RISING

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Through the fire



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NIRA FLEISCHMANN

DEDICATION AND EDITORIAL

We're dedicating this women's issue to Nira Fleischmann, a courageous and gifted sister, friend, ex-psychiatric inmate, member of ON OUR OWN and our editorial collective.

Nira died suddenly on New Years Day this year. She was only 26. According to the Coroner's Report, Nira died of "bronco-pneumonia". She suffered from a recent and severe lung infection, which virtually collapsed both of her lungs. The infection progressed very rapidly and prevented sufficient oxygen from getting to her blood and brain. Tragically, Nira's body was too weak to fight the infection. Shortly before her death in Toronto General Hospital, Nira was on a respirator and in a coma.

Nira's death is particularly tragic—not only because of her young age but because of her outstanding literary and artistic talents. Above all, Nira was a poet. She spoke and found release through her painfully sensitive poems and drawings. Nira had the rare ability to speak the unspeakable, to express some of her own and other women's deep personal pain, suffering and longing. Like Sylvia Plath, she was a poet of the dark side of the soul. Some of Nira's poems, and excerpts from her diary (written while she was last incarcerated in a psychiatric ward in 1983), appear in this issue. Nira was also a gifted and developing artist. She enjoyed and excelled at drawing and etching. A few of her sensitive drawings also appear in this issue.

In addition, Nira was a brilliant student and teacher of literature. During the last two years, Nira was a graduate teaching assistant at York University where she was working on a Ph.D. degree. Her MA thesis was titled *The Heroism of Survival*; we hope this brilliant work is published soon. Her students loved her; her professors respected her and admired her talent.

A few months before her death, Nira was also becoming involved in the antipsychiatry movement including the Ontario Coalition to Stop Electroshock. Although nervous at speaking out, she gave a moving personal statement against shock during the Coalition's public hearings in Toronto last October. (See her "Anti-Shock Testimony" in this issue.) Nira was terrified of being threatened with shock and ending up again in a psychiatric ward. While incarcerated, she saw some of her sister inmates being shocked and wrote a poem about these horrifying experiences. (See her poem "E.C.T." in our April 1984 issue, p.14A.)

Nira shared our deep distrust of and anger toward psychiatry. She knew all too well what it was like to be subjected to psychiatric abuses—forced "treatments" such as neuroleptics, antidepressants and involuntary committal—and being dehumanized by psychiatric labels and staff. A medical doctor or psychiatrist, she once told us, got her addicted to "pain-killers" a few years ago. Sometimes, Nira tried to get off her pills, which her doctors routinely and callously prescribed for her. However, her inner pain, gnawing fear of further incarceration and sense of hopelessness were too deep and overwhelming. We hold these pill-pushing doctors (We wish we knew their names) personally responsible for contributing to Nira's death.

During the seven months that we were privileged to know and work with Nira, we knew that she was in almost constant pain and turmoil while wrestling with and ultimately succumbing to her inner demons. She was an incredibly sensitive and vulnerable person, sometimes suicidal. The support which some of us gave or tried to give her was obviously not enough. We wish we had given her much more, or been able to persuade her to join a women's support group.

Despite her great suffering, Nira somehow found the energy and strength to edit virtually all of this issue—an incredible feat considering her emotional state and the fact that she had never before done any magazine editing. Nira was working on this issue right up to the time of her final hospitalization.

In dedicating this women's issue to Nira, we are also dedicating it to the millions of other women who, like Nira, have also suffered the pain of surviving the oppression inherent in our sexist and alienating medical-psychiatric system and society. With this issue, we are not only commemorating our deep personal loss of a gifted sister, but rededicating ourselves to continue the struggle against psychiatry's oppression of women, and celebrating women's victories over this oppression.

Phoenix Rising Editorial Collective

WHY WE'RE LATE WITH THIS ISSUE

Our sincere apologies to all our readers, subscribers and supporters for the long delay (almost 1 year) in publishing and mailing this women's issue. There are two main reasons. The first related to the editorial collective itself. We've gone through some heavy crises during the last few months—the recent death of Nira Fleischmann, a collective member and the main editor for this issue. Nira's death was a big personal loss for us and of course her family. So, we're proud to

dedicate this issue to her. (See our dedication/editorial.)

The second reason is our continuing funding problems, which we share with most other alternative, antipsychiatry magazines. Last year, we had no funding for about six months. However, last fall, we were fortunate to get funding for this issue from the Secretary of State-Women's Bureau. We thank the Secretary of State for making this issue possible. We're also pleased to announce that our next spring/summer issue will feature *The Canadian Charter of Rights and Freedoms* and its impact on psychiatric inmates. The Human Rights Law Fund of the Department of Justice is funding this Charter issue. So, we're OK financially until this summer.

To help us survive and pay our rising production costs, we had to raise our newsstand price for individual copies from \$1.75 to \$2.25. Also, our new subscription rates include mailing costs and cover 4 issues per year: \$8 (in Canada); \$10 for foreign subs.; and \$15 for institutions. But one thing hasn't changed—we're still committed to sending a *free copy of any issue to any psychiatric inmate or prisoner upon request.*

Our sincere thanks for hanging in with us. We'll continue working hard to get out 4 issues a year and continue speaking out for inmates' rights and against psychiatric oppression.

Phoenix Rising Editorial Collective



write on

NOTE TO READERS: *Phoenix Rising* assumes any correspondence sent to us may be reprinted in our letters section unless otherwise specified. Please tell us if you would like your name withheld if your letter is printed. Letters without names and addresses will not be accepted.



Dear Sisters & Brothers,

It was exciting to discover your magazine *Phoenix Rising* exists, as the voices of many individuals caught up in the vicious cycle of the psychiatric industry most often go unheard.

Enclosed is a small donation toward an issue of *Phoenix Rising*, which I would like to share with a group of friends struggling to create a self-help group in the Albany, N.Y. area.

I became familiar with your magazine through an excellent article written by Lilith Finkler called, "When your friends freak," in the Spring 1984 issue of *Kick It Over*.

Unable to continue a "career"—Servicing for Dollars—in a local outpatient Day Training Center for the "chronically mentally ill," it was a relief to hear someone else discussing the practical alternative of direct responsibility at a personable level toward our fellow human beings. Such alternatives are in great need at a time when labeling/segregating/processing commodities, through the professionalized human service industry, consume the very essence of our humanity in the creation of "career clients" and "normalized, certified staff" sustaining a schizophrenic society!

Personally, for reasons of conscience, I find myself no longer able to work within this system.

In hope and struggle for justice,
Wendy Decker

Dear folks,

Congratulations on the excellent coverage on electroshock in your April issue of *Phoenix Rising*. I doubt if any magazine or journal publication has ever been as reasonable in presenting both sides. The material you covered is an excellent primer for altering the uninformed public to cliched comments by pro-shock professionals who seemingly sound plausible but who cover-up research evidence on the destruction of the brain cells caused by high voltages of electricity.

It is unfortunate that I did not have such information at my disposal a year ago last April when I found myself in the most unlikely position of speaking up against electroshock on WBAI-FM radio. I happened to be in the studio during a phone debate on electroshock between Ted Chabasinski—whom you mentioned was at the age of 6, one of the youngest children in the USA to be shocked by Dr. Lauretta Bender—and the co-chairperson of Columbia Presbyterian Hospital's psychiatric department. When the moderator refused to let Ted tie in the connecting link between his own shock experience and the Nazis, Ted protested and then hung up.

Knowing next to nothing on the subject and not even having been told what the subject was before walking into the studio, there could not possibly have been a greater David and Goliath mismatch. Rather than leave the anti-shock position undefended, I slipped a note to the moderator offering to debate the psychiatrist. This was perhaps the most exciting experience of my life. I figured that since I assumed that I would lose anyway, there was nothing to be afraid of. A week later, I received a call from a friend who said she had received a call from an acquaintance describing this most amazing debate on ECT on the radio in which this man Bill held off this psychiatrist from Columbia Presbyterian Hospital. I took this wonderful compliment to mean that I had fought the pro-shock forces to a draw . . . If only I had read your issue first.



Also, being no fan of the highly unethical Freud, I enjoyed Leonard Frank's quotations from Dr. Freud. However, no such list would be complete without the following quotation, my favorite of Freud's:

"I know the objections there are to making use of patient's reports, and I will therefore expressly state that my informant is a trustworthy person, well capable of forming a judgement . . . I make use of his communication without asking his consent since I cannot allow that a psychoanalytic technique has any right to claim the protection of medical discretion."

Keep up the good work,
Bill Cliadakis
Co-Chairperson
National Committee for Preventing
Psychotherapy Abuse
New York, N.Y.



August 9, 1984

Dear Phoenix Rising,

My name is Jacques Courmier. I am 27 years old. I am French Canadian. I have been incarcerated for the last 7-1/2 years. I have an affective disorder, which means that I am both manic-depressive and schizophrenic—a double-whammy. I have been in a serious car accident and a coma, after being attacked by a patient with a pool cue in 1977. This was my first experience with E.C.T. (while I was in a coma). I no longer remember my attacker or the attack. Despite all this, I am undertaking studies at the University of Toronto to become a doctor. If I do not succeed (not because of lack of intelligence, but because of my illness), I plan to become an R.N.A., through Vocational Rehabilitation Services. The point I want to make in this letter is that anyone with the desire to make it *can* make it. Sure, there are odds to overcome and a price to pay—but, isn't it the case with everything in life? So, cut out the excuses, and do what you wanna do, and be who you wanna be.



Soon I am to be released from prison—and from bonds of darkness which grow in concentric rings about those of us who have spent years in confinement, both psychiatric and penal.

I am wanting to remain in contact with all of you, and to send you a contribution for a subscription as soon as I am able to do so.

Indeed, I hope you gain enough financial support to continue publishing. We need your presence.

Tom Hudson,
Wichita, Kansas



Bravo!! Just read the April issue, given to me by a fellow incest survivor who has been through the 'system' (ie. shock treatment, anti-depressants, tranquillizers, etc.).

Her experiences, and your magazine, have motivated me to withdraw from medication now.

Loved the issue, and am looking forward to reading more. Keep up the good (and courageous) work. Enclosed is \$6.00 for a year's subscription.

In solidarity,
Edmonton, Alberta

We are proud to award this issue's *Phoenix Pheather* to the Ontario Coalition to Stop Electroshock. This year—largely through its members' dedication, hard work, and successful public educational efforts—the Coalition has distinguished itself by making electroshock a public and political issue.

Last January, at a meeting of the Toronto Board of Health, several members gave moving and courageous personal testimony against shock. They succeeded in persuading the Board to adopt a motion which called for an "immediate moratorium" on shock without free and informed consent. Serving as a pressure group, last summer the Coalition helped persuade Health Minister Keith Norton to appoint the Electroconvulsive Therapy Review Committee.

Angry over the obvious medical and pro-shock bias of the Review Committee, the Coalition and other citizen groups again pressured Norton to appoint a shock survivor. Finally, last September, On Our Own member Carla McKague—a lawyer and a shock survivor—was appointed to the ECT Committee. And, as a result of the committee's refusal to hold public hearings, the Coalition decided to organize and to hold *its own* hearings on shock, which were fully open to the public. (See 'Coalition Update' article in this issue).

We wholeheartedly support the Coalition in its ongoing struggle to abolish this barbaric, brain-damaging procedure masquerading as "treatment", and wish the Coalition many more victories.

GIVING THEM THE BIRD



Our first *Turkey Tail* goes to Dr. Samuel A. Malcolmson, the Medical Director at Queen Street, for his now well-publicized memo of August 16, 1984.

When asked by the Metro Police Intelligence Bureau to be informed of any "... current or past patient who has verbalized threats against the Pope or the Queen," Malcolmson quickly complied. His memo to the medical staff (all of three paragraphs long) instructed them to ignore the law that requires every ex-inmate's written consent, prior to the release of any information concerning his or her hospitalization.

Because he considered inmates and ex-inmates a "... risk to public safety," Dr. Malcolmson blatantly dismissed a vital section of the Mental Health Act. Aside from breaking the law, Malcolmson's actions also likely succeeded in perpetuating myth of the psychiatric inmate as violent and dangerous to society.

For his flagrant disregard of the legal and ethical duty of psychiatrists to protect patient confidentiality at *all times*, we award our first *Turkey Tail* to Dr. Samuel A. Malcolmson.

We're awarding our second *Turkey Tail* to the Ontario Friends of Schizophrenics (OFS). Like psychiatry, the OFS actively promotes the medical-model myth of "mental illness," particularly the myth of "schizophrenia."

Last October, the OFS ran an ad about "schizophrenia" which appeared in all buses, streetcars, and subway cars of the TTC. The ad reads:

*Schizophrenia strikes 1 in 100.
For more information about this
biochemical disease, contact:
Ontario Friends of Schizophrenics,
Suite 401, 112 St. Clair Ave. West,
Toronto M4V 2V5. (416) 926-1974.*

Despite the "educational" or publicity efforts of the OFS, there is no credible scientific evidence to support its repeated claim that "schizophrenia" is a "biochemical disease" or a form of "mental illness." (For a comprehensive critique of "schizophrenia," see *Phoenix Rising*, vol. 3, no. 3.)

Furthermore, as a publicly-supported transportation system, perhaps the TTC should consider giving more advertising space to human rights issues, including the Ontario Human Rights Code—which is virtually out of sight in all subway stations.

WOMEN AND THERAPY

by Pam Munro

I recently attended the **Women and Therapy Conference** held in Toronto. Yes, I know it, I'm one of the few female students who could afford it.

As expected, Freud and his followers (psychiatrists, psychoanalysts etc.) were exposed (alas, once again) for their true nature—violence against women. We heard that in most therapies, “patients” are placed in isolation and locked into dependency by “experts” who sit in silence, display little empathy, and never indicate having had similar experiences. Women are perceived as biological masochists and therefore are blamed for every atrocity performed on them. Women are drugged, locked away, shocked and sexually assaulted, all “for their own good”.

Paula Caplan presented a fascinating workshop of “The Myth of Women’s Masochism”. Having lived with a man for four years and recently come out, I immediately identified with some of her observations of straight women. She observed that most straight women don’t want to believe that men are changing very slowly, if at all. She pointed out that we are so accustomed to nurturing men that we are deeply moved and appreciative of any small sign of feeling sensitivity and turn to them for friendship. Most men, even the more “sensitive” men, don’t turn to each other for emotional support, they turn to women.

Many new and old ideas were generated at the Conference. Sandra Pyke, in her workshop on “Gender-Fair Therapy” (or, as she preferred, Feminist Therapy), spoke of the need to demystify the therapy process by making explicit one’s philosophy, perspective, and approach. Sandra reminded us that the client is paying for a service and has a right to know about that service in advance. The first interview should really be free. To be fair, the therapist should be prepared to help the client find another therapist in the case the client doesn’t like her or his style.

Breaking down the power differential is an ongoing often difficult process. The very nature of a “pay for service” relationship is one based on power. In response to this, Rita Nemiroff (workshop on “Empowerment”) suggested five steps the therapist should take before even seeing clients. The overall question to ask is, “What am I doing, and for whom, and for what purpose?” Then work through the following steps:

1. List five ways in which gender, class and colour has shaped my life.
2. Prepare an analysis of my education formation, beginning with grade one. (Ex. what did I learn? how did I learn?)

3. Ask yourself, “Can I let go of the above? Am I ready to let go of the external validation of signs of authority?”

4. Ask yourself, “Where do I feel power? Where do I feel powerless? And, “what are our true supports when we feel powerless?”

5. I want clients to have a better life. I must define what I mean by a better life.

To break down the power differential during therapy, Sandra recommended that the therapist be open to: answering questions about herself, expressing her own feelings, revealing similar experiences, revealing her weaknesses, providing the opportunity to the client to differ from or argue with her position, and viewing the client as the expert—after all, the client knows herself best. Sandra also suggested loaning money to clients and helping clients with outside projects, events, people or agencies.

Empathy is an extremely important component of therapy. One part of empathy is having the same experiences including class, ethnicity, age, life experiences.

CHRISTMAS

Tinsel droops
from a wreath over . . .

Nurse: (with a notepad)
What’s the matter?

Patient: (in a thick
Portuguese accent)
I want to go home
for Christmas.

The nurses wheel
her away, strapped
to a trolley, for
electro-shock
treatment.

I try to stop them,
screaming: “For God’s
sake, it’s Christmas!”

They give me a
sedative.

by Heather Duff



Mental health and violence against women: a feminist ex-inmate analysis

This position paper is the result of a workshop conducted at the 10th Annual International Conference on Human Rights and Psychiatric Oppression, held in Toronto, Canada, on the 14-18 of May, 1982. We do not claim to be representative of all female ex-inmates, given our feminist perspective, our largely middle-class values, our race (white and North American), and our age (24-37). The members of the workshop met to discuss alternatives to the mental health system in dealing with issues of violence against women. As female ex-inmates we have concerns such as rape, battery, expression of anger, that need to be addressed from our particular perspective. As feminist survivors of psychiatry and violence, we have formulated an analysis which has not been articulated by either the women's movement or the anti-psychiatry movement.

Psychiatry and Violence Against Women are Related

1. We are raped, battered and blamed. We are told that we have asked for it, and our childhoods are endlessly psychoanalyzed to find the causes of our "masochistic" behaviour. This perpetuates the cultural acceptance of violence against women by "blaming the victim".
2. When we react by getting upset and getting angry at being raped, battered, pushed around and down, we get therapy, we get treatment, we get locked up in mental institutions. There, we are subject to further sexual harrassment.
3. When we do turn for support to the system, we learn several things. Men define and judge our experience in terms of quality and quantity: rape on the street by a stranger compared to rape by an acquaintance, lover or stranger, compared

to incest and battery. Certain groups of women are particularly vulnerable according to their status in society: women who are prostitutes or on welfare are taken less seriously than white, middle-class married mothers of two. This causes women to become divided amongst themselves, by denying the pervasiveness of violence in our culture and in all of our lives. The similarities in our experiences with violence are far more important than the particular details or circumstances of our victimization.

4. As women, our credibility is challenged, our words are discounted, regardless of what we say. If we outwardly express our pain by crying or shaking with rage, we are labeled hysterical. On the other hand, if we remain calm, the experience of our victimization is denied or not taken seriously. For ex-inmates, or any women with a record of "mental illness" this problem is exacerbated.

Our status as madwomen is used against us: we're lying, we're hallucinating, or it doesn't matter anyway.

5. Our sisters, feminist therapists, also fail us. They label us, reject us, or just don't see the connections we do.
6. We join the ex-inmate movement, and expect to find sexism, but will not accept the failure of members to recognize it and be accountable for it.
7. Finally, we recognize that we are in a position of relative privilege. We are out of the psychiatric system, we are articulate, and the support we get from each other gives us the strength to speak out. Our passion and urgency derive from the awareness of all the women who are truly powerless; in institutions or after-care, restrained, secluded, drugged,

shocked, raped and battered. We have a responsibility to protest what is happening to our sisters.

Where Do We Turn When We Are Raped or Battered?

Raped or battered, we suffer overwhelming feelings including rage, shame, humiliation, powerlessness, self-doubt and guilt. Where do we turn? Ideally, we would turn to our friends, family and community, expressing our anger and sadness safely, and mobilizing our resources in struggle for change. Sometimes, and to some degree, this happens. Unfortunately, these resources for support are usually not available to us, for a variety of reasons.

One set of concerns arises from cultural attitudes which are male defined and violent. When we turn to the people we love, we find that it is still unacceptable to admit that we have been victims of rape or battering. We are judged, or blamed, or politely ignored. It is also unacceptable to admit a need or desire for support.

The second set of concerns has to do with race, class, status, and geography. Some of us have access to resources over which we are more or less in control. For instance, white middle-class feminists may receive support from some women's groups when raped or battered. Some of us can afford to take a vacation or even move if we need to get away from dangerous or abusive living situations. A wealthy woman who protests battering has a better chance of buying sympathetic and competent legal assistance. A woman who can visit a private physician or nurse practitioner or other health care giver is in a much better position than one who must go to an emergency room for first aid, and there are countless other ways in which women of colour, poor women, women who are prostitutes, single women, and lesbians are denied help.

If we admit that we have been raped or battered, need support, or are hurt by our victimization, we are very likely to come into some contact with the mental health system. Some of us turn to counsellors or therapists because we are told that this is the place to go if we are in emotional distress. Some of us know that we need to talk to other women about what is happening to us, and the only place to find each other may be in a "support group" in a crisis centre or clinic within the mental health system. Others of us are turned into the mental health system because we protest or show our pain. A battered woman who knocks on neighbours' doors, screams for help, or repeatedly calls the police runs a serious risk of being committed to a mental institu-

tion. This is particularly true for women less valued by the dominant culture, including black women or women without economic power. Increasingly, we even find that grassroots or feminist alternative support systems are being infiltrated, co-opted, or swallowed whole by the mental health system.

How The Mental Health System Acts Against Us

1. The first problem is that the mental health system is involved at all. Violence against women is not a personal or individual issue, but a political reality. The concept of "mental health" implies a corresponding pathology, but women who are survivors of violence are not ill. The focus on the individual is destructive for two reasons. Firstly, focusing on the individual woman leads to blaming the victim, either overtly, or through the therapeutic process which searches for hidden motivation. Secondly, this focus leads to an assessment of the rapist/woman-violator as suffering from an individual pathology. He is thus relieved of responsibility for his actions, and the socio-cultural values encouraging violence against women are obscured. We know that rapist/woman-violators are not peculiar. Women's experience attests to this fact. All women are aware that men assume our availability and access to our bodies. This constant is manifested in every facet of our lives; in advertising, in harassment on the street, in the media and in our relationships. Even by the admission of mental health professionals, it is impossible to distinguish between rapists and "normal" men.

2. Increasingly, our experiences with violence are described in terms of pathological syndromes. For example, there have appeared in the literature references to "rape trauma syndrome", "incest survivors' syndrome" and "battered woman's syndrome". Women have uncritically welcomed this acknowledgement of problems that, until recently, were never discussed. As feminist ex-inmates, we regard as destructive the involvement of mental health "experts" in this discussion. We don't need psychologists to validate our experience. Some of the negative effects of this are:

a) A hierarchy is created based on the circumstances of our assault. A woman who is gang-raped or raped by a stranger on the street is seen as having undergone a "better rape" than a woman who has been raped by an acquaintance. However, a wo-

man who is raped by her husband or the man with whom she is intimately involved is seen as pathological for remaining in the relationship. Women who have been raped by men of a "lower" race or class are seen as "more raped" and are therefore more readily believed.

- b) When we label our experiences in terms of syndromes, these artificial distinctions act as barriers to recognizing our common experience, supporting each other and working together for change.
- c) This delineation is a theft of our right and our responsibility to describe our own oppression.
- d) The delineation of symptoms and reactions implies a correct response, which seeks to further control us.

The involvement of the mental health system in issues of violence against women tranquilizes us, either literally or figuratively. At worst, some of us are committed to institutions, and there we are subjected to the most blatant forms of psychiatric oppression: forced drugging, shock, isolation and restraint. Even at best, in relatively supportive, sympathetic and non-coercive situations, we are talked out of our anger or "helped" to direct it in more "appropriate" ways.

The mental health system is insidiously taking over the fight against violence against women. In the face of dwindling financial resources, mental health centres are scrambling for new clients and popular projects to be funded. Women's centres are being co-opted, at least in the United States, by becoming professionalized and by accepting monies from mental health agencies. Another example arises in the fight for compensation for victims of violent crime. Where compensation is provided at all, as in Canada, validation of pain and suffering as well as of medical expenses is required. We reject the notion that we need a psychiatrist's note to prove that we are upset about our assaults.

Why Feminist Therapy Has Failed Us

Women in a patriarchal culture face threats of violence and oppression on a daily basis. Feminism is a base of support for women to come together to share collective strategies on how to deal with our common oppression. Women come to the Movement with huge expectations and needs for support, and, often disappointed, turn to feminist therapy to fill that void. This and other uses of feminist therapy are extremely problematic to us as feminists who are former psychiatric inmates who recognize therapy for what it is: a mechanism of social control.

Treating women's emotions as illness does nothing to "restore sanity". Instead, this bastardization of



caregiving is a direct contradiction to the central tenet of feminism, i.e., that the personal is political. The history of professionalization of medical treatment should give us as feminists some ideas about the problems of this hierarchical misogynist structure. Men became frightened of the power of women practicing healing arts, labeling them witches and lesbians and worked to destroy them.

Individualizing, personalizing, or therapizing the very real social-cultural, psychological, and physical oppression in women's lives isolates women from themselves, each other, and collective action. This process leaves us without a healthy way to talk about and deal with our feelings. As soon as a woman's feelings become too intense, they are fragmented, segmented, and isolated to the professional therapeutic realm. Therapy is so powerful that it can not only cure the victim, but also cures the victimizer. Would it not be healthier to cure the disease?

As long as feminist therapy exists, with its arbitrary distinctions between therapist and patient, and between women who are well enough to be helped by feminist therapy and those "too sick" and in need of institutionalization, so will psychiatry as a method of social control for all women. All women are vulnerable to the excesses of the psychiatric system. Feminist therapists, like all therapists, maintain the

professional privilege to commit women against their will, "for their own good". This imbalance in power cannot be overcome. Even more unfortunate is the fact that feminists in growing numbers are becoming therapists, thus supporting the notion of extreme emotions as illness with the need for hierarchical professional intervention.

The kind of "patients" feminist therapists want and attract are not at all dissimilar to the type of female patients Schofield (1960) found with whom male therapists "felt they were most efficient and effective with in therapy". The patient was described as being between the ages of 20-40, without any advanced education. This has been described as the "YAVIS syndrome": young, attractive, verbal, intelligent and successful, or in other words, "normal". Continuing to treat "normal" problems as though they were abnormal not only preys on women's needs for support via an exploitative capitalistic relationship, but also perpetuates and abnormalizes caregiving. This does nothing to change women's perceptions of ourselves as "sick", and in need of "objective", "professional" treatment. Instead, by continuing to "treat" women in "professional therapeutic" relationships, one fosters those self-doubts about one's mental health. If women are treated in abnormal ways, we will feel abnormal, and will expect others to view us as such.

How can feminist therapists realistically expect us, the victims of psychiatry, to believe that this or any other "radical therapy" is different and will bring about any real change, when they cannot clearly delineate what feminist therapy is or critically differentiate between feminist therapy and other forms of psychiatric oppression? A somewhat dated, but still relevant study by Broverman et. al. (1970) illustrated that clinicians, both male and female, utilize masculine definitions of mentally healthy behaviour. It is not altogether surprising that those characteristics associated with being a mental patient — passive, dependent, manipulative, and indecisive — also fit the socially prescribed role for women in this culture. The feminist therapy movement has suggested that consumers of their services need to become better consumers by learning how to choose a therapist. This "How to Buy a Refrigerator" argument not only diminishes the therapist's responsibility, but also ignores women who have had all choice removed in their lives, most directly by the legal system, and more indirectly by the coercive nature of the therapeutic

process. This is a more subtle and insidious form of the "blame the victim" theory which has been used to explain virtually every kind of oppression. In addition, this argument totally ignores class issues. Few women can afford to buy a refrigerator — or an hour of talk — when they are now making less than 59¢ for every dollar a white man makes in North America. Estimates show that this figure will be even lower for women of colour. How does an hour of talk change the fact that incest, rape, battery and harassment are cultural norms? All therapies are an abstraction of reality which keep women talking and not acting. Describing our experience as rape syndromes, as symptoms of incest victims, or by the proper psychiatric label for battered women does not change our experience. Feminist therapies, like all other therapies, are not looking to the survivors for guidance, but are instead relying on clinical judgement. They are not asking us, they are placating us. Treating our anger and our pain as illnesses gets therapists paid by the insurance schemes, but leaves us feeling more "crazy". Nor have feminist therapists taken a position on other critical issues: civil commitment, coercive voluntary commitment, shock, forced drugging. How then are we to trust you? And finally, feminist therapy is a contradiction in feminist terms. Feminism began and continues to survive relying on consciousness raising as the essence for women to come together and support each other, and to collectively define our issues. We are aware of the harmful consequences of having "professionals" define and deal with our issues. Feminist therapy is a part of the psychiatric system and as such it is a method of social control which mirrors larger society.

A Place for Anger

Our anger is real. Our anger at our experiences of oppression as women and as psychiatric inmates, of being raped, beaten, locked up, drugged, shocked, is valid and strong. It is not a "symptom" to be drugged or therapized away. It is, instead, a source of our power, a fuel for our outrage and our activism. We will not allow anyone — psychiatrist or feminist therapist — to convince us that we are sick because we are enraged, because we refuse to calm down and "adjust" to a "reality" that defines us as inferior. We completely reject the idea that there is an inappropriate degree of anger, an inappropriate length of time for our anger, or an inappropriate object for our anger. We rejoice in our identities as madwomen, as furies, strong and proud.

A Summary of Our Analysis

The powers that stand behind the systematic attacks on people who are labeled "mentally ill" are the same powers that stand behind woman-hating in the lives of all women, behind the continuation of violence against women. This power is contained in our economic system, within the system of male supremacy. As feminists and ex-psychiatric inmates, this is the point where issues of violence against women and psychiatric assault come together.

The psychiatric system is, in effect, a microcosm of society. Both play an important role in defining how society will operate. In western capitalist society, men are responsible for participation in the labour force, while women are expected to be primarily child care providers, to reproduce the labour force. These sexual roles have become defined as "normal". However, the psychiatric professionals have defined these roles in terms of pathology. The male sex-role is generally regarded as "mentally healthy", while the female sex-roles are "mentally unhealthy". Thus, women are placed in a position whereby, to be healthy women, we must be "unhealthy people", and to be "healthy people", we must be unhealthy women. Women become both "normal" and "abnormal" at the same time. Furthermore, when one defines another human being as "abnormal" or "different", one can more easily justify any maltreatment, including rape, battering and other violence. In the extreme, we see those defined as "different" (Jews, mentally retarded, etc. in Hitler's Germany or Stalin's Russia) as examples of justified violence against those who are different.

Just as the psychiatric system serves the purposes of social and economic control around the world, so violence against women serves the social and economic control of women.

As female ex-inmates, we take back the pride and dignity of self. We take back our credibility. We demand the right and power to define our own needs, issues, and most importantly, our own strategy for support and political action, without "professional" intervention.

Where We Go From Here

1. We challenge the feminist community to recognize our experience and analysis as ex-inmate women, rather than ignoring us, rejecting us as sick or crazy, or being embarrassed by us. In particular, we ask feminist therapists to acknowledge the contradiction in what they do.
2. We demand that men accept the responsibility for violence against women, and acknowledge the perva-

siveness of misogynous assault, and the fact that this violence is a deliberate strategy for social control. We challenge them to stop rape and abuse.

3. We ask our brothers in the ex-inmate / anti-psychiatry movement to recognize the sexism in the movement, at this conference, and in their relationships. We ask neither for an admission nor a denial of guilt, but a willingness to develop an analysis of this sexism, and a commitment to develop strategies for change.
4. We all have a responsibility to be aware of the role of class, race, and status in the violation of women. We accept this responsibility personally for ourselves, and most explicitly refuse to take part in an anti-rape movement that lends credibility or strength to an attack on people of colour.

We know that it is important to recognize the value of the least powerful among us, not only because we care about our sisters, but because it is in

our own self-interest to stay together. If lesbians are unsafe and unvalued, every one of us is in trouble. If the rape of women of colour is condoned, then all women are potential victims. If we fail to recognize that a husband forcing sex on a woman is rape, then we are saying that the men we choose always have access to our bodies. If it is acceptable to rape or beat up prostitutes, then not a single one of us is safe. If madwomen, "retarded" women, or women prisoners are acceptable targets for violence, we can all be subject to assault. We speak here because silence is complicity, and we will not consent to assault on any woman. Each of us is precious, unique and valuable.

Virginia Raymond, Austin, Texas
 Dana Lear, On Our Own, Toronto
 Rene Bostick, Columbus, Ohio
 Laurie Bradford, Big Mama Rag,
 Denver, Colorado
 Judi Chamberlin, Summerville,
 Massachusetts
 Susan Price, Toronto
 Jeanne Dumont, Ithaca, New York





Rights and Wrongs

PSYCHIATRIC MALPRACTICE: THIS CASE IS ABOUT POWER

Greta Hofmann Nemiroff

Note: The following two articles are printed with the permission of Greta Hofmann Nemiroff and *Communiqu'Elles*.

INTRODUCTION

"In every house where I come, I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women and men."

from the Hippocratic Oath, *Stedman's Medical Dictionary*, 579 (22 edition), 1972.

"The Discipline Committee has viewed professional misconduct related to sexual impropriety with a patient to embrace a wider gambit of improper conduct than sexual intercourse. It is a most serious offence which has resulted in the revocation of the physician's licence to practice in some cases."

The College of Physicians and Surgeons of Ontario, *College Notices*, Issue No.4, July, 1982.

... "sexual activity with a patient is unethical."

American Medical Association, *Principles of Medical Ethics*, 1978.

... "It is unethical for the therapist to engage in sexual activity with a client."

American Association of Sex Educators, Counselors and Therapists, *AS-SECT Code of Ethics*, Washington, D.C., 1978, III-7.

The old myth in the early movies and peep shows went something like this: a pretty woman went to the dentist and was given gas to dull the pain. When she was totally unconscious, the villain-dentist would proceed to 'have his way with her' . . . only to be stopped at the 'critical moment' by the hero's sudden outraged arrival.

Times have changed. Local anaesthetic has put an end to these dental traumas and the availability of heroes seems to be diminishing.

However, there is still one privileged corner of medical practice which requires absolute privacy for the doctor and the patient: psychiatry. While there are many success stories in the annals of psychotherapy, there are also many cases of malpractice which involve gross misuse of the doctor's power through sexual encounter, prolonged treatment and occasional indiscretion in the area of confidentiality. When this happens, what is the patient's recourse? In one-to-one therapy, there are no witnesses. Few people would like to have their innermost lives trotted out before witnesses and courts; some even seem to feel protective towards the doctor who has abused their trust. On the other hand, it is often important for the patient's mental health to 'do something' about the situation; needless to say, it is also important for the protection of future patients.

In this article, I am reporting in detail the specific case of the Morton family and their decade with a Montréal psychiatrist who is still on the staff of a reputable Montréal hospital. I have had access to all the family's files on the case; as well, I have interviewed both Ruth and Melanie Morton in some depth. I have reviewed a large sampling of material on therapist-patient relationships from both medical and legal points of view. In order to delineate ways in which psychiatric patients may improve their vulnerable situation, I have interviewed various professionals in the health and mental health industries as well as various consumers of their services.

The presenting case: THE MORTON FAMILY

"I thought this was my shame and my pain. I really thought this was what I deserved in life . . ."

Melanie Morton

In 1969, the Morton family was in a state of crisis. Both parents, Ruth and Sam, were free-lance writers and money was tight. They had two adolescent daughters to educate and were having difficulty with them. Ruth's father was becoming senile and her mother, who was suffering from cancer, found it increasingly difficult to look after him. Ruth herself suffered from intense stomach disorders for which her family doctor had prescribed Valium. This made her sleepy, affectless, and impaired her ability to work for the income the family badly needed, as well as her ability to enjoy life. Sam also had health problems which later proved not to be 'psycho-genic' at all. He was to die 11 years later of a second operation on a brain tumor. Joyce Morton was 18 years old and very rebellious. The parents had difficulty controlling her. However, it was Melanie, the youngest, who presented the greatest problems, impelling the family to seek help. Due to a school phobia while a student in elementary school, she was brought to a psychologist who was able to help matters for a while. However, when she was 15, she contracted mononucleosis, which kept her out of school for several weeks. When the time came for her to return, she became immobilized at home and suffered serious stomach upset any time she was to go to school. She had few friends and tended to stay at home reading or watching television.

NOTE: All relevant names and places have been changed in order to protect the identity of the people involved, with exception to references to actual officers of the Corporation professionnelle des médecins du Québec and other figures external to the case who are identified by name.

A good friend of the Mortons had been seeing a psychiatrist, Dr. A., and reported good results. Ruth Morton, having observed positive change in her friend, contacted Dr. A., thus starting the 10-year relationship the family would have with him.

Dr. A. initially saw them a few times as a family, and then saw them separately. After a few sessions, Joyce flatly refused to continue; she didn't like him. Sam was to have ambivalent feelings towards the doctor for years, Ruth remembers: "He kept quitting and going back. He didn't know where to go." The most faithful patients were Ruth and Melanie. Ruth initially felt helped by him and her stomach condition improved. She now questions his methods, and feels that other ones would have been better. When she would mention her concern over Melanie, he would say, "You deserve a daughter like that!" The effect of this, she says, was: "I had such a low opinion of myself that I took what he said and tried to improve." He told her repeatedly that it was her fault Melanie was in the state she was, and that she must under no circumstances interfere with or ask Melanie about her sessions with Dr. A.

Ruth now regrets having followed his advice, which she feels alienated her from her daughter, made her untrustworthy in Melanie's eyes and was instrumental in prolonging Melanie's treatment. This alienation was made worse by the fact that the Morton family became friends with Dr. A. and his wife. The doctor is a gregarious man who enjoys lavishly entertaining his friends at huge parties in his opulent home. Many of his guests are patients of his. The Mortons themselves made an entire new set of friends whom they met through Dr. A. Dr. A. and his wife proved to be generous friends, giving the Mortons gifts of silverware, china, crystal. While Ruth now sees his influence as a divisive one, since he saw members of the family separately and often pitted them against one another, at the time she felt proud of their friendship, and helped by it. Now she knows that in therapy, you must . . . "actually help yourself. But for the first time in my life someone was really listening . . . I became very dependent on him."

From the ages of 15 to 23, Melanie had regular sessions with Dr. A. During this time, she finished high school and university, but lived in a high state of anxiety which was partially caused by his treatment, which I will further discuss below.

As he had with her parents, Dr. A. created a state of utter dependence in

Melanie. She could come and see him whenever she felt unhappy. "Just seeing him for 10 minutes would give me confidence," she says. "It was a fix." Thus she never learned to rely on herself to resolve problems. "He never helped me to find out who I was," she regrets. It was difficult for her to develop or express criticism of him when he was so close to her parents. If she did complain about his strange, riddle-like responses or apparent boredom with her, her mother would say: "When you start to talk like a healthy person, you'll get good feedback. Telling him garbage will get you that result."

It was also painful for her to see Dr. A. and Mrs. A. as guests in her house. "I couldn't have the psychiatrist in the house, seeing the dynamics between me and my parents. It was horribly embarrassing . . . This person who sits up on a throne, you don't want him in your house. It's like your wildest dream come true. My psychiatrist is sitting at my table with me. It's too embarrassing for me." It was her finding that the psychiatric relationship does not lend itself to social intercourse. This view, of course, is upheld by many theoreticians in the field: "There is no relationship other than the therapeutic one."

However, the real crux of Melanie's complaints against Dr. A. is sexual impropriety with her. It started one day when she was 16 and had a cold. Dr. A. suggested giving her a physical examination to make sure the cold was not 'psychosomatic.' During this process, when she was stripped down to her underwear, he began to stroke her arm and asked her if she liked it. "I'm not supposed to like it when a doctor strokes my arm," she responded, and he stopped. In retrospect, Melanie feels that this was an indication of things to come, but . . . "I was so naïve at that stage. It was making me damn uncomfortable (the arm stroking), but I didn't even see it as a sexual overture." Neither did she identify it as a sexual overture when in following sessions he would frequently ask her how she would like to sit on his examining table in her underwear or perhaps a bikini, allowing him to touch her and letting herself enjoy it. Eventually, when she refused to comply, he dropped the subject for a while.

Dr. A. tried another tactic. He asked her to bring in *Playboy* magazines and point out to him the women she preferred. Melanie acceded but felt violated by these questions. Sometimes he would show her slides of women undressing, masturbating, or of a couple copulating. By the time she was 18, he had identified her problems as largely sexual. The problem was that she hated men, he said, and

she was in therapy so that she wouldn't emasculate them. The only way to cure her, it seemed, was through masturbation. It started with her lying naked under a sheet alone in a darkened room, listening to his voice on a tape. The tape began with hypnotic relaxing suggestions, and then suggested masturbation. She was to masturbate alone in the room with him watching at a distance. Ultimately he came forward and 'massaged' her, working his way down from her shoulders to masterbating her himself. While the latter happened in all about ten times, it was suggested at almost every session. Melanie had had no previous sexual experience and these sessions caused her great anxiety and guilt.

As well, she'd ". . . walk out feeling sexually frustrated. He'd work me up to a state of sexual excitement on one level, even though I'd feel guilty and ashamed." Because of her naïveté about sex, Melanie feels he gave her false expectations through the importance he placed on his 'cure'. "He made me feel there was something beyond sex . . . he preyed on a fear I had. *Playboy* was so removed from me . . . those voluptuous women!" (Melanie, who is a tall, nice looking slim young woman, sees herself as 'skinny.') "It gets scary when someone builds up sex to watching and fantasy . . . to that kind of titillation."

It must be said that Melanie did not entirely give in to this treatment. "One day I questioned him when he suggested masturbation. 'Are you sure this is done?' I asked. He just said: 'Masters and Johnson!' and I said 'Oh!'" In those days the work of these two sex therapists was widely publicized, and Melanie was impressed by this appeal to authority. He would also try to manipulate her into agreeing to be masturbated by feigning boredom when she would mention other aspects of her life. He would sit with his eyes closed, as if in a deep sleep, and only open them at key words, such as 'sex' or 'suicide.' His standard response to her 'resistance' was: "Do you want to go in there and deal with your problems or not?"

Melanie emphasizes the extent to which the doctor's 'treatment' was connected with his need for absolute power. For example, when he would come to get her in his waiting room, he walked ". . . with little tripping steps. But when I was naked under the sheet in the examining room and he was fully dressed in a suit, he'd swagger, his posture would change and he'd look down on me laid out there on the table . . . it was a whole power trip."

Dr. A. made Melanie feel that she had to have an orgasm for *him*, that he had to teach her how to "live with men." "Never tell a man he's wrong," he said.

"Never?" I asked. "Never!" he responded firmly." Usually he would look at his watch while he was masturbating her, urging her to reach her orgasm quickly . . . he was a busy man. "A normal woman would be multi-organic by now!" he would exclaim irritably, or "Are you cooperating?" In a desperate attempt to placate him, Melanie would say: "Just give me one more minute!" Eventually he became very angry with the fact that he could not induce orgasm in her; he violently pushed his hand into her vagina and tore her hymen. Later on, when Melanie had a boy friend and realized that there was "nothing wrong" with her sexually, she triumphantly reported this to Dr. A., certain that she was cured and the masturbatory sessions were over. "As hard as it may be for you to believe me," he responded, "we still have to continue."

In 1979, after nine years with Dr. A., Melanie moved to Toronto where her sister Joyce was living. She was 23 years old, had finished her degree, had passed an exciting summer at a prestigious art school, and had no further plans: "I was paralyzed by the fear that I wasn't going to get anywhere in the world. I didn't see any future for myself and became totally involved in myself." At her sister's suggestion, she entered therapy with a Toronto psychiatrist, to whom she recounted her experience with Dr. A. Eventually she told her mother about her experiences as well.

Ruth was in her 10th year of therapy with Dr. A., a therapy which had degenerated into unfocused discussions about literature. Ruth and Sam were shocked, terribly disillusioned and guilt-ridden about their unknowing encouragement of Melanie's years of therapy with Dr. A. They decided to fight back, to try and protect future patients from Dr. A.'s 'cures.'

Both Melanie and Ruth have separately said that they look upon their years with Dr. A. as 'lost years.' "I feel outrage and rage at what I comprehend now, I feel betrayed, I feel I have lost years," says Ruth Morton.

The battle

"Although sexual feeling may arise naturally within the treatment relationship, because of the nature of that relationship, sexual activity, regardless of the circumstances, is considered by law and by the profession an exploitation of the patient; although mores change, basic moral principles endure, and the wise therapist adheres closely to those principles . . . in the best interest of his patient, of himself, and of his profession."

B. Nicholi, "The Therapist-Patient Relationship," *The Harvard Guide to Modern Psychiatry*, Cambridge, Mass: The Harvard University Press, 1978, pp. 17-18.

What then could the Mortons do in late 1980 when they heard Melanie's story?

The first thing they did was to confront Dr. A.; the very day Melanie told her what had happened, Ruth had an appointment with him. She got Sam to accompany her and they confronted Dr. A., who did not deny his 'treatment' at all. In fact, he admitted masturbating Melanie and justified it by saying how hostile she was to men, and that he was helping her to overcome this hostility. He was to deny this later when questioned by the Corporation professionnelle des médecins du Québec (hereafter called the Corporation). That afternoon he simply tore a book by Masters and Johnson off his shelf and threw it dramatically on the desk in front of Ruth and Sam. They did not think to ask him to show them passages which supported his forms of therapy. Indeed, those very authors had made an uncompromising stand on the issue of therapist-patient sexual relations some years before:

We feel that when sexual seduction of patients can be firmly established by due legal process, regardless of whether the seduction was initiated by the patient or the therapist, the therapist should initially be sued for rape rather than for malpractice, i.e., the legal process should be criminal rather than civil. Few psychotherapists would be willing to appear in court on behalf of a colleague and testify that the sexually dysfunctional patient's facility for decision making could be considered normally objective when he or she accepts sexual submission after developing extreme emotional dependence on the therapist.¹

At a later date, after a formal complaint had already been lodged with the Corporation, Dr. A. called Ruth to come to his office; he was displeased when she arrived with Sam, but carried out his plan of appealing to their sympathy on behalf of his wife and children. He asked them to tell Melanie to call off her complaint against him to the Corporation. Naturally, they replied that they would not and that their loyalty belonged with Melanie. This was their last direct contact with him.

Subsequent discussions with Melanie revealed that she knew of other women who had similar experiences with Dr. A. Early on in her treatment, he had sent her for group therapy at a hospital where he was on staff. When she would go out for coffee with the other women from this group, she would hear them exchanging information about their

'treatment' at the hands of Dr. A. They were, without exception, young, good-looking and of limited financial means. This seems to be consistent with patterns of sexual contact between therapists and clients:

It is a striking fact that the great majority of instances of sexual contact between therapists and clients are ones in which the therapist is male and the client is female. In addition, the female client is often quite a bit younger than the therapist . . .

. . . Another issue that needs to be considered is the unequal distribution of power between the therapist and the client. Not only is the therapist in a higher status position by having the client come to him or her, but by virtue of being a therapist he or she is assumed to be more powerful and more competent than the client. In addition, the therapist has another major source of power. Knowledge is power and the therapist finds out a great deal about the client's needs, weaknesses, etc., without having to reveal anything about him-or-herself. . . . The relationship is simply not fair when the therapist turns it into a sexual relationship.²

Most of these young women had not had previous experience with psychiatrists and had no means of judging the validity of Dr. A.'s 'treatment.' One of his ex-patients says in her deposition to the Corporation: "I had never seen a psychiatrist before and had no gauge for knowing if I was in the care of one who could or could not be of help to me."

Ruth made appointments to see two therapists, one with a PhD in psychology who had conducted the group Melanie attended, the other a psychiatrist at another hospital who knew Dr. A. Both men hold senior positions in their respective hospitals. In both cases they had heard from women patients that Dr. A. had masturbated them. One said that he considered Dr. A. "sick," while the other called his treatment "unethical, immoral and unprofessional." Neither of them, however, had done anything to intervene in Dr. A.'s treatment; Dr. A. himself has since disappeared from the staff of one hospital and continues to practice at another.

The silence of these mental health professionals is by no means extraordinary:

The psychiatrist has usually heard about his or her colleagues' sexual misconduct from patients in the course of therapy, during consultations, and, perhaps even more often, from other psychiatrists who share such information with the expectations of collegial confidentiality. Often this information is in the form of vague rumors or even gossip. Rarely is there what could be considered well-documented evidence. Thus, on the one hand the psychiatrist typically has

only hearsay knowledge and on the other hand he or she is bound by section 4 of Principles (American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, 1981), which requires us to "safeguard patient confidences within the constraints of the law." Given these limitations, it is easier to do nothing. Even when one does recognize the often ignored affirmative duty to "expose" such a colleague, one often feels helpless to do anything about it. Doing nothing, then, can become the accepted norm of professional behaviour, while taking action to expose a colleague can become the deviant exception to the norm. Whatever the reasons for this collective failure to act, in retrospect it creates the appearance of a "conspiracy of silence." Critics, for instance, charge that the ethical duty of confidentiality to the patient is used hypocritically to cloak the offending therapist, that psychiatrists are more responsive to the requirements of professional etiquette and to each other than to their professional responsibility to patients, and that the canons of ethics protect the profession and not the patient.³

Furthermore, there was probably little in the professional training of either man to make him feel a categorical ethical responsibility to confront the situation and try to correct it:

*The study of ethics, as it applies to medicine, has not been warmly embraced by medical educators or medical scholars. Questions about what is and what is not ethical continue to flounder in a tangled web of opinion, often passionately held; these questions have not been submitted to careful disentanglement and analysis in seminars and scholarly journals. Thus, we do not possess a systematic body of knowledge on an ethics for medicine. It still needs to be developed.*⁴

Meanwhile, in early 1981, Melanie wrote a detailed statement on her case to the Corporation. It took ten months for Dr. Rémi Lair of the Corporation to respond to in a letter, stating that since Dr. A. had "... formally denied having performed the kind of therapy..." outlined in Melanie's letter, and since they now had two differing versions of the facts as well as a lack of evidence, they were unable "... to conclude that this physician committed a fault of a non-natural nature."

They did not offer any suggestions for further action, of course, and one had the impression that as far as the Corporation was concerned, the case was closed. It is standard that there are difficulties regarding evidence in such cases:

The plaintiff who complains of exclusively mental injuries may also have a

*difficult time proving the element of damages. Not only are his allegations intangible and difficult to demonstrate to the judge and jury, but they also tend to be somewhat speculative because of the state of knowledge about mental illness.*⁵

Ruth undertook to respond to Dr. Lair's letter by asking that the case be reopened; she mentioned her interviews with the two therapists who had admitted knowing of Dr. A.'s practices. As well, she claimed to know other women who had suffered a similar fate at Dr. A.'s hands and were willing to come forward. Dr. Lair immediately answered this letter, informing her that it was essential to bring direct testimony from these witnesses before the Disciplinary Committee of the Corporation. All other information could only be construed as hearsay evidence. He was also willing to meet with the Mortons and their legal counsel, but not in the presence of Dr. A.

In March, 1982, a year after Melanie's initial letter, the Mortons, two other women ex-patients of Dr. A. and their counsel met with Dr. Lair at the Corporation office. Each ex-patient was interrogated separately and asked to submit a signed statement. When Melanie requested a hearing with Dr. A. in attendance, she was told that this could take place shortly. The procedure would be the following: Dr. A. would hire his own lawyer and the Corporation would select and provide one for Melanie. Unlike the civil courts where the plaintiffs appoint their own lawyers, the Corporation exercises full control over the plaintiff's representation. Neither Melanie's family nor the lawyer whom she had selected to represent her could be present. When Melanie's lawyer objected to this, Dr. Lair granted that her presence could probably be arranged, but that she would not be permitted to speak. Melanie, then, was expected to come forth with no moral support whatsoever and with the defence mechanisms selected for her by a Corporation whose existence is predicated on its protection of the interests of its members, medical doctors. One could not have very much confidence in this set-up, which is a common one throughout this continent:

*Although professional organizations tend to mete out severe sanctions against those therapists conclusively shown to have engaged in sexual relations with their patients, the deterrent effects of this policy are not substantial. Violations are rarely reported and many professional organizations have neither the inclination nor the resources to pursue those that are. As a result, practitioners know that the disciplinary process is invoked against only a small fraction of the offenders.*⁶

The above article goes on to claim that many professional organizations have

difficulty in getting members to risk sitting on disciplinary boards. One assumes that many practitioners would simply rather not know about the behaviour of their peers.

In any case, no effort was made by the Corporation to call a hearing. The report of this case simply came before the Complaints Committee of the Corporation, and it came to the conclusion that Dr. A. "... did not commit any infraction to the Medical Act or to the Code of Medical Ethics in regard to the therapy..." Melanie had received. On the other hand, the Committee said that it did make "certain recommendations" (whose content was not revealed) to Dr. A., and that it requested that a visit be made to him by the Professional Inspection Service. This was the last communication from Dr. Lair. As of July 26, 1982, the case was to be considered closed. When one of the other ex-patients wrote to Dr. Lair requesting a copy of the *Code of Medical Ethics* be sent to her, he neither replied nor sent it.

The Corporation's response to the Mortons is ambiguous and riddled with contradictions. If there was no infraction, one wonders what recommendations had to be made, and why the Inspection Service was called upon to visit Dr. A. We must also recall that when Dr. A. was originally confronted by Ruth and Sam, he himself did not deny having committed these practices and indeed saw no fault in his treatment of Melanie. There would be numerous therapists agreeing with him; occasionally they write in defence of their position. Despite ethical positions articulated from Hippocrates to the present day, there are many instances of this 'witnessless' malpractice. There is no doubt that the "socially isolating nature of the usual private psychiatrist's office and practice might be considered contributory to his engaging in erotic behaviours with his patients. In addition, the very process of the psychotherapeutic transaction fosters a special quality of emotional intimacy."⁷

*If the therapist finds that attractive patients need his "reassurance" more, he should question his motives to make sure that he provides sexual services to the elderly, ugly, to the crippled, to the incontinent, to the same sex, and to all races, creeds and religions. We are not aware of a direct intervention sex therapist who meets these criteria.*⁸

Furthermore, none of the patients who testified against Dr. A. had ever felt that she suffered from sexual dysfunction in the first place. Hence not only was his 'cure' unethical, but his 'diagnosis' was clearly self-serving and without reference to anything other than his attraction to the patient in question. In ten years, he had never made an overture to Ruth Morton.

Ruth began to realize that the Corporation and appeals to 'due process' were slow and ineffectual. She was also discouraged by the withdrawal of one of her witnesses who had apparently received satisfactory private financial compensation from Dr. A. She began to contact other people who might give her advice. Because of my involvement in the feminist issues, she contacted me. It immediately struck me that the basic issue was one of power: power of the doctor over the patient, of the Corporation over the public. The mental health industry is a powerful one, and it is in the nature of professional organizations that their ranks close when one of their number is threatened. Because it is a political issue, I thought it should be treated as such. We had to establish a power base.

I gave Ruth a list of several people to contact, first and foremost being Mona Forrest, Director of the Women's Information and Referral Centre, an educational and advocacy organization for women.

It turned out that Ms. Forrest already knew of Dr. A.'s treatments, but had been unable to find someone willing to come forward. In late July, the Women's Information and Referral Centre undertook to act on behalf of the Morton family by contacting both the Commission des droits de la personne du Québec (hereafter called the Human Rights Commission) and Mme Nicole Boileau, Directrice du cabinet, Cabinet d'état à la condition féminine.

The Human Rights Commission looked into the case and informed Melanie in October, 1982, that they could not undertake further investigations because of the lapse of the time limitations on her recourses before the courts. They informed her that she would have the right to pursue the matter further by lodging a complaint with the Disciplinary Committee of the Corporation, but she would have to bear all legal costs unless she could get help from Legal Aid.

Mme Boileau was impressed by the case and put the matter into the hands of a lawyer, Mme. Michelle Bussières, who worked with the Cabinet d'état à la condition féminine. Me Bussières could not undertake the case herself, but placed it in the competent hands of Me Lorraine Duguay, a Montréal lawyer. Me Duguay, who is representing Melanie and one of the other plaintiffs, has made representation to Dr. A.'s lawyer, but without actual charges being filed, the matter has come to a standstill.

In order to further the case, the experts' only recourse is to bring criminal charges against Dr. A. These women are fully aware that . . . "the client who wishes to make formal complaints about treatment by a psycho-therapist has a formidable task. Perhaps the most threatening obstacle is that of privileged

communication. He risks loss of privacy, embarrassment and damage.⁹ Not only do the women in this case not have sufficient financial resources, they are unwilling to put themselves in the positions of defendants in a case where they are plaintiffs.

This is not an isolated case. I myself know of a male psychiatrist who has shown great sexual impropriety with his male patients. Although he too has been excluded from the hospital system, he has a thriving practice, the government continues to honour his medicare number and he is answerable to no one at all. Some time ago he was actually given free publicity by a local paper which featured a photograph of him as an 'expert' in a story on a specific kind of mental problem. Melanie herself was to discover that the psychiatrist whom she had subsequently seen for some time in Toronto, is now being charged by several ex-patients on the grounds of sexual impropriety. Like Dr. A., he professes to be liberal and mixes with his patients on a social level, giving lavish parties. Although he had not made overtures to Melanie, she is disillusioned with psychiatry: "If I ever go again," she says, "I'll go to a woman. I need a long period to trust my own judgement and not go every week to find out if I'm thinking right."

One hopes that Melanie would fare better with women psychiatrists. However, of the two women psychiatrists to whom the Mortons turned for advice, only one was willing to take a public stand. The other, a well-established and politically powerful woman within the medical community, expressed great sympathy but conspicuously withheld any actual support. Another woman psychiatrist told me that most hospital departments try to regulate such matters by getting rid of the offending doctors. This does not change the doctor or the chances of impropriety at all; it merely eliminates liability for the particular hospital.

This psychiatrist went on to tell me of a doctor in her department whom everyone knows sleeps with his attractive women patients. This situation is apparently resolved by his peers referring only men and older women to him. They consider him good in those cases. It is dubious that a department can exercise control of a doctor's entire private clientele. As well, I would find the professional judgement of a doctor who sees young women as prey to be questionable with older women, whom he presumably sees totally undesirable.

Many women doctors have arrived at their profession through conforming to those patriarchal values which are validated by universities and medical schools. It is not only difficult for them to break

rank in a system where they have little power; it is also difficult for them to retain a vision uncluttered by the self-interest prevalent in the profession.

Thus perhaps it is more important to ask if a doctor is a feminist or ethically committed to eradicating sexual harassment than simply if it is a woman. However, in most cases, one can expect a female therapist to not seduce her female patients.

The tragedy in Québec is that even should Dr. A.'s licence be revoked tomorrow, there would be nothing to prevent him from hanging out his shingle the day after as a self-proclaimed 'therapist' or 'sex therapist.' There is little control over what passes for therapy and often people are seriously harmed. The only sanction Dr. A. would suffer under such circumstances would be the loss of a 'régie' to act on his behalf, plundering the tax payers' money for inferior and actually dangerous services.

The Mortons are at a stalemate. Their last recourse is to 'go public,' which is why this story is simultaneously being covered in *Châtelaine* and *Communiqué-Elles*. We hope that these articles will be catalysts to long-term changes within the mental health professions, the Corporation and the consciousness of health consumers. On the other hand, Melanie's and the other women's stories cannot be changed.

What steps, then, must be taken to protect the public from this kind of abuse?

Patient power

"Having blown the whistle on him made me realize my latent strengths and that I'm a person who will speak up when I have strong beliefs."

Melanie Morton

There are various levels at which changes have to be made and responsibility taken, from the public organizations down to the individual health consumer.

The Corporation

While the response of the Corporation professionnelle des médecins du Québec to the Mortons' case does not hold out much hope for similar cases of malpractice, we must still use that channel of complaint when necessary, bearing in mind that the Corporation is like other professional boards and associations and has no subpoena power and little expertise in criminal or other evidentiary procedures.¹⁰ While Dr. Suzanne Lamarre, a Québec psychiatrist, has suggested elsewhere that a special committee of women doctors be struck within the Corporation to review cases such as the Mortons', our experience cited above indicated that gender is not a sufficient de-

terminant of *active* advocacy for women. Members of such a special committee must be *known* advocates for human rights, and they must be well-informed of feminist critiques of the traditional doctor-patient relationship.

Perhaps a good starting point within the Corporation would be to have a Status of Women committee which sets on-going goals for itself and takes the initiative of informing the public of its work.

Since there is a clear conflict of interest in disciplinary committees formed solely of doctors, the Corporation should invite members of the public to participate on such committees in equal number to the doctors and representatives of the Corporation. These public members should be working in fields unrelated economically to the health industry.

The Corporation also has the responsibility to loosen some of the shrouds of secrecy surrounding it. It owes the health consumers of this province a clear accountability. While self-mystification is a salient characteristic of the profession, Québec doctors are paid from the public purse (and often subsidized in their studies from the same source) to deliver services clearly defined as 'medical acts.' All holders of medicare cards should receive from the Corporation a booklet containing the following: an abstract of the *Code of Medical Ethics* with accessible sources for the complete version cited, statements on the rights of the physician and the patient and an account of the procedures for complaint with addresses and telephone numbers.

While it may be argued that the above is a massive and expensive job, it is my contention that doctors, among the highest paid professionals in Québec, can afford to inform their public more accurately than they do. Such a project would have the additional value of protecting the doctors themselves from unrealistic expectations on the part of patients.

Since the Corporation offers doctors every form of due process and protection, the same courtesy should be offered to the plaintiffs. They should be allowed counsel of their own choosing as well as the supportive attendance of at least four other people of their choice. It can do the reputation of the Corporation or of the individual doctor no good whatsoever to be associated with the 'kangaroo court' procedures described in Melanie's case.

The State

The government, which administers the health insurance money of the population, is clearly responsible for keeping the public better informed of its rights. Consumer education for use in the health system should be taught with hygiene

and social studies in the school system. The state itself could also undertake to publish a brochure on patients' rights with appropriate addresses and telephone numbers for the citizens of this province.

Individual therapists

The practice of therapy itself requires further reassessment and critiquing from both within and outside the profession. The very fact that Melanie and Ruth Morton were kept in therapy for nine and ten years respectively is a questionable practice. Melanie only escaped by moving to another city, and Ruth claims that her last years were wasted in idle chit-chat.

It should be a matter of course for therapists to explain to the patients at the outset what therapy is, what might be reasonable expectations to have from this process, what the therapist's own individual methodology is and to then place the therapy within some sort of initial time-frame. Naturally it is not always possible to know how long a case will take. However, it is possible to set a period after which the patient and doctor will together evaluate the case and decide on the next step.

There is little evidence that open-ended psychotherapy of the kind practiced by Dr. A. (not to speak of many of his colleagues) does other than to create a life-long situation of dependency. Melanie, when talking of the inordinate length of her own therapy, said: "I could go on for my whole life talking about my insecurities . . . I'm never going to be perfect. I began to feel he was dragging it out, but I didn't trust my instincts enough to get out." Not only do such prolonged therapies tie the patient into a situation of extraordinary dependency and lack of confidence in their own judgement and insight, they also monopolize the physicians' services, which are in great demand. One sometimes get the impression that rather than clinging patients, there may also be clinging therapists. Eric Berne's injunction might apply here: "If you want your patient to be your therapist, be sure first that you can afford to pay him your usual fee."¹¹

A note must here be made of non-medical therapists who also can be guilty of the same sort of malpractice and misuse of power. Often they are even more difficult than medical doctors to bring to justice. However, psychologists who offer therapy should be members of the Corporation professionnelle des psychologues du Québec (1575 Henri-Bourassa West, No.510, Montréal H3M 3A9, 337-3360). Social workers belong to the Corporation professionnelle des travailleurs sociaux du Québec (5757 Decelles, No.335, Montréal H3S 2C3, 731-2749). However, the latter organization does not occupy itself specifically

with therapy.

There are also other kinds of therapists who have more ambiguous credentials that may still be valid. There are some who have no externally validated training at all. It is important to know the credentials of your therapist, and you have the right to inquire. If you choose, on the basis of recommendations by trustworthy people, to work with a therapist who does not have medical training, it is important to make sure that they have a 'back up' in the medical profession in case medication or hospitalization is necessary.

The important thing to remember is that if a therapist, medical or non-medical, behaves with impropriety, you should act immediately by confronting the therapist, seeking support and information from an advocacy organization, and where possible, by bringing the matter before a licensing board such as the Corporation.

The "Client"

or consumer of mental health services

Ultimately, the public must become educated to expect better services, and if we don't get them, to demand them.

Doctors as individuals and as a profession have particular interests to protect: their discipline, a freedom to use their particular knowledge in the diagnosis of disease and its treatment and the maintenance of standards in their profession. They also share economic interests as a group. Patients also have particular interests to protect: the right to know the truth, the right to be free from harm at the hands of a doctor, the access to the best skills and information available for each person's specific case and the right to complain and seek redress in cases of malpractice.

Very often, however, patients feel inordinate loyalty to their doctors, and are reluctant to question them, to complain about them or to change them. Their reluctance is often supported by the doctors' own manner of aloofness, unwillingness to answer questions or offer explanations, and general hurried behaviour which diminishes the patient to a notation in an over-booked schedule. Because of women's generally oppressed status in our society, we are the most likely to feel intimidated by authority figures. We must learn to listen to and respect our own insights and gut feelings. If we find a psychiatrist's (or any other doctor's, for that matter), behaviour to be improper, it is worth pursuing redress; we can afford to err on the side of mistakes. Here are some things the health consumer must bear in mind and do under such circumstances:

1. Remember that you are paying for these services from your taxes. You have a RIGHT to good service from a professional in the same sense that you have in a restaurant or store;
2. You have a RIGHT to demand a second opinion on your condition and appropriate treatment;
3. If you are dissatisfied with the service you are getting, you have a RIGHT to change doctors without apology. Your doctor has the OBLIGATION to forward your chart to his/her replacement;
4. If a doctor does not give you adequate care or treatment or is guilty of malpractice, you have a RIGHT to know the number of your medicare invoice and complain directly to the appropriate ministry;
5. If you have any doubts about your therapist's treatment of you, speak to trustworthy friends about it in order to check out your reactions. Often this can confirm your feelings and give you the courage to confront your doctor, ask for a referral elsewhere or present your case to a higher body;
6. Before choosing a therapist, interview a few, where possible. Inform yourself of his/her record with women. Inquire at various women's organizations to see if they have any information regarding specific doctors. If you, on the other hand, have such information, share it with others. Let women's groups know about it. See Note 13 for a short list of such groups.

Patient advocacy

At the moment there are no advocacy associations concerned directly with the welfare of the non-institutionalized psychiatric patient in Québec. I am not aware of any such organizations in Canada either. There are a few in the United States; the National Committee of Preventing Psychotherapy Abuse (NCPA) has been in existence for over a year. Its main functions are to refer people to appropriate services and therapists, to help people who have complaints, to provide resources and written material on the subject and to help people with similar problems to network. In addition, this group publishes a regular newsletter. For its address and that of other groups in the United States, please consult Note 12.

The formation of an organization for the protection of medical consumers and clients in therapy is long overdue in Canada, not to speak of Québec. Such an organization could supply information about the different forms of therapies, about medications, about patients' rights and the procedures of complaint and about the work of specific doctors. It could also provide a listing of competent lawyers versed in the intricacies of malpractice. It would be a lobby for

better procedures in private practice and stronger peer control within the hospitals. It would also help abused patients break through their isolation and sense of guilt by giving one another mutual support.

While some of us might feel sufficiently powerful to taken on the psychiatric and medical establishments alone, most of us need a power base. This is political reality; this is the politics of the doctor-patient relationship. Very wisely, physicians have formed their own organization. It is due time for the patients to follow suit.

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11. Eric Berne, *Principles of Group Treatment*, New York, Oxford University Press, 1966.

12. Addresses of associations for the prevention of psychotherapy abuse in the United States:

- a) National Committee for Preventing Psychotherapy Abuse, 61 W. 57th Street, New York, N.Y., 10010, (212) 663-1595. Contact person: William Cliadakis.
- b) Walk-In Counselling Centre, 2421 Chicago Avenue South, Minneapolis, Minnesota, 55408, (612) 872-8642. Contact person: Gary Schoener, Executive Director.

ed Patients, Box 9682, Fort Worth, Texas, 76102, (817) 738-1828. Contact person: Sylvia Diamond.

- e) Aptus, c/o Mae Gross, 666 West End Avenue, New York, N.Y., 10025.

13. Montréal women's groups you can contact:

Women's Information and Referral Centre, 3585 St-Urbain, Montréal H2X 2N6, (514) 842-4780, 842-4781.

Centre de santé des femmes, 16 est, Bd St-Joseph, Montréal H2T 1G8, (514) 842-8903.

Some good books dealing with the subject:

Phyllis Chessler, *Women and Madness*, Avon, 1973.

Robert Castel, Francoise Castel, *The Psychiatric Society*, New York: Columbia University Press, 1982.

Dorothy Tennov, *Psychotherapy: the Hazardous Cure*, New York: Anchor Books, 1975.

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Psychiatric Malpractice: An Update

Greta Hofmann Nemiroff

In the September issue of *Communiqu'Elles* there was an article written by me called *Psychiatric Malpractice: This Case is About Power*. The article described the case of a local psychiatrist who sexually abused his patients, and it was based on interviews with some of his victims. The article demonstrated how this case was first ignored and then suppressed by the Corporation professionnelle des médecins du Québec. It also pointed to evidence that various colleagues of Dr. A's were knowledgeable about his practices and ignored them. Dr. A. is still in practice and is on the staff of yet another hospital in the city. I have been asked by *Communiqu'Elles* to

give an update on events. Did the article in *Communiqu'Elles* have an effect?

So far, it has had no visible effect on the actual case in question or on the psychiatric establishment. The article, with an explanatory covering letter, was sent by the Morton family (Dr. A.'s patients) to all the principals involved as well as to the head of the psychiatry department where Dr. A. is now working. There has been no response. For all intents and purposes the cases of Melanie Morton is arrested exactly where it was in the summer of 1982.

The article elicited some interest in the media, and I was interviewed on two radio programs. The Morton family is being interviewed by a journalist from a large mainstream newspaper. On the basis of the article in *Communiqu'Elles*, I have been asked to talk at the YWCA and at a conference on Women and Therapy in Toronto in the fall.

I have received several telephone calls from women who claimed to be victims of malpractice. I directed them to the advisory services of the Women's Information and Referral Centre. In addition, I received information of a very interesting new book written by a woman psychologist, Dominique Brunet, who works in Montréal. It is called *Les Thérapies au féminin*, and I recommend it to interested readers.

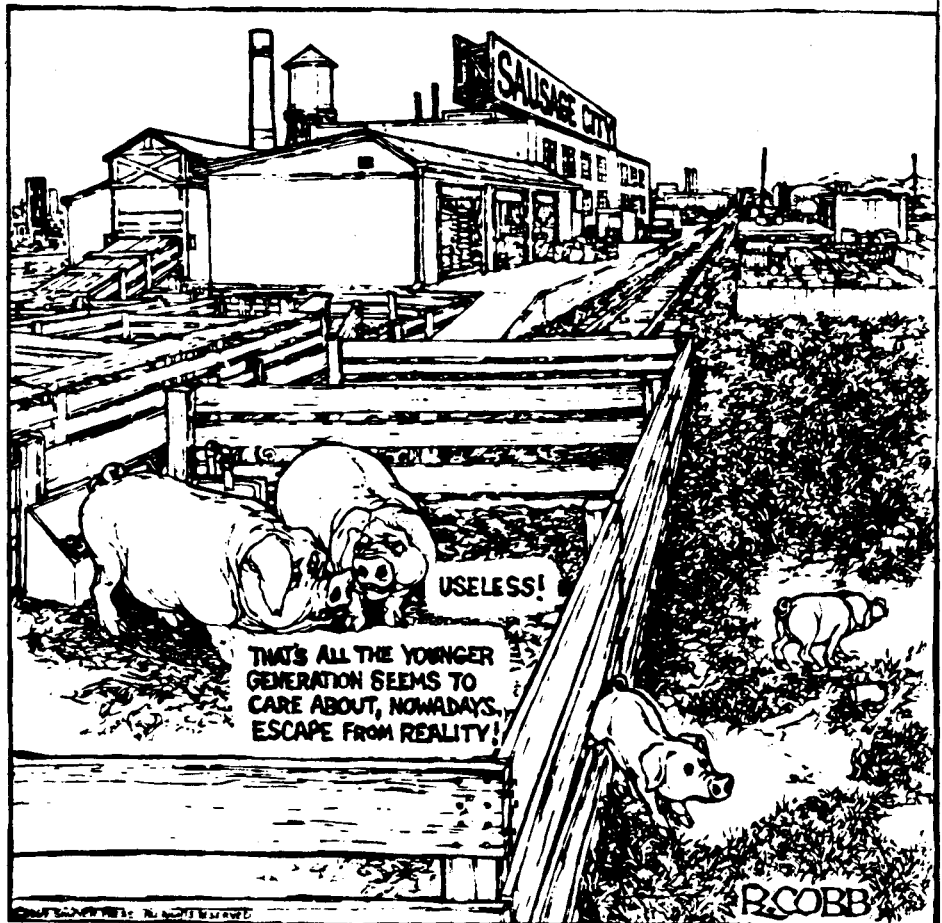
Two organizations for ex-psychiatric patients were drawn to my attention. They are: La Croix Blanche, 847 Cherrier East, No.101, Montréal H2N 1H6, 521-4800 and Autopsy Inc., 332 St-Luc, No.3, Québec G1N 2S8, (418) 529-1978. The latter group seems to be very active in fighting for the abolition of electric shock treatment. One of their members is now on the Committee for Mental Health of Québec, which is under the aegis of the Ministry of Social Affairs. They are interested in all matters concerning the rights of non-institutionalized psychiatric patients.

On occasion I have spoken to women social workers who have read the article. Many women therapists and social workers have been interested in sharing the article with their colleagues. My informants tell me that while their women peers were interested in pursuing matters in discussion, men tended to simply slip off with a "very interesting." I am pleased to report that this article was read and discussed by a small group of students in the first year of McGill medical school; they found it instructive to learn about the functioning of the Corporation, to which all of them *per force* belong.

However, I fear that the subject will not be adequately reviewed and discussed in medical and therapeutic circles. Within the medical profession, most malpractice discussion revolves around the issue of malpractice insurance and its astronomical costs. It would be refreshing to

see the subject of malpractice relegated back to the domain of ethics, where it belongs. The relative scarcity of writing on the topic in current professional journals, and its exclusion from most conferences and meetings of therapeutic personnel, leads me to think that many practitioners are under the impression that one need only "deal" with the subject once, if at all, in one's training. In my view ethical questions form the subtext of the life of any professional en-

gaged in the "helping" professions. There is no reason to imagine that such people would be immune from the temptations and negligence of all other ordinary mortals. It would be encouraging to see this delicate topic addressed more widely, more profoundly and with more accountability, especially by our local medical professionals. In the absence of their involvement, however, the public still must assume the responsibility of keeping them honest.



A Case of Knowing Yourself:

An Interview With Carol Stubbs

Late last spring Phoenix members Coreen Gilligan and Patricia Urquhart spent a thoroughly enjoyable afternoon talking with Toronto painter and writer Carol Stubbs. The following is an edited but still informal version of their conversation.

CAR.: What happened . . . I was married when I just turned 17, and by the time I was 21, I had four children. I'd gone to university *and* had my fourth child. I spent two years there and found the load of having four kids . . . Well, it's self-explanatory because I was pretty worn out, I was pretty tired, I wasn't well, and then I had a miscarriage while at school. Stupid me, I went right back to school after the miscarriage! I collapsed—that was about it.

So I landed in a psychiatric ward where I was given about 86 shock treatments within three months. I was given regressive therapy which put me back to the level of a five or six-year-old. Sometimes I had three shock treatments a day. And then, I really didn't feel the shock treatments did me any good. My memory was gone, actually for about a good year of my life. During that period I don't remember having one shock treatment.

PAT.: Did the "regressive therapy" mean that they were giving you so much shock that it made you incapable of functioning at anything more than a very elementary level?

CAR.: Yes, that was the method of doing it. I know I was on medication, too, but that's what I understand was the main method of doing it. They certainly did get me to a very basic level, too: My mother came to see me after awhile, and she found me sitting on my bed sucking my thumb. I said, "Hel-l'o, Ma-ma!" Later she told me that she'd just walked out into the corridor and cried, wondering what she'd done wrong.

COR.: There wasn't interaction with the psychiatrist, sitting down and talking about the kinds of things in your life?

CAR.: Well, they must have talked with me. Like I said, my memory left me at that time, and I have no recollection of that period in the hospital. All I know is that I woke up one day and said to the nurse, "Oh, I've been here a long time. My husband's going to be mad at me." And she started to laugh because I was feeling guilty that my husband was wondering where I was. Something told me it was a long time.

I lost my memory for that whole period—the time in the hospital and *also* the time just before—about a year and a half altogether, I guess. For example, I don't remember moving to the place we were at when I went to the hospital; to this day I can't remember anything about that place, or how we got there, or when—even though I've seen the place since, and seen pictures of it. I just can't remember.

And once I was allowed to go home to visit—it was Christmas so I got to come just for dinner. I walked in and I saw these four little boys and I said, "My, what lovely boys! Whose boys are they?" They were my own boys and I didn't even know them, you see.

COR.: You didn't have any memory of how you got in the hospital either?

CAR.: No—I was told how I got there. I'd come home from school one day, and I was very upset. Apparently, I told my husband there were birds in the house, and I was very panicky about these birds being in the house. And he had told me

there were no birds in the house. Then I just sort of fell to pieces, and I got on the phone—this is what I was told—I got on the phone and said to my very good friend, "Maureen, you better come over and take me to my doctor, because I'm having a nervous breakdown." So she came over and took me to the doctor. He put me to sleep and sent me in an ambulance.

PAT.: Neither you nor your husband knew that you were going to be put on this regression therapy?

CAR.: No. I guess they discussed it with my husband, but like me he was really quite ignorant of the psychiatry and accepted everything. I have since asked him who gave permission for me to have all those shock treatments, and he said he doesn't know whether he was formally asked, or whether he signed anything. He doesn't remember; he didn't see any significance in it.

It was as if they were saying, "This is what we have to do, we're going to do this for her," and we just said, "YES, YES, YES," to everything.

COR.: They never presented you with any options? It was just taken for granted what they were going to do?

CAR.: I think so. I don't know for sure, because like I said my memory was gone for that period. I remember my girl friend, Maureen (who had brought me into the hospital) came to visit me, and she had a very good friend of mine with her. This woman had been a close friend of mine through university, but I didn't remember her at all, and I still to this day cannot remember her before she came to visit me in the hospital. I told her, "I'm sorry but I don't recognize you." She just sort of laughed, and they were glad to see me.

COR.: How does it make you feel now—the whole aspect of memory loss?

CAR.: Well, I don't like the feel of it, but I feel that it was the least torture I went through.

PAT.: Did you mention it to your doctor when you found out that you couldn't remember things?

CAR.: I don't know. It was all so foggy. It was all so disarrayed—nothing was organized within me. I just went along. It was either sink or swim, and I just went along. I wasn't even very conscious of any organized effort. If I was led in for a shock treatment, I just went.

COR.: And the method, then . . . ?

CAR.: I understand that they didn't use pentathol back then. I know they do now, but they didn't at that time. So it must have been quite harassing. It's amazing how we accept things—that's the problem. We're sort of led to accept, whereas I think that people should have control, should feel a little bit of control over what happens to them. . .

I don't think the shock treatment worked, and I'll tell you why. I literally lived in a blanket of fear, then—I couldn't get away from it. Whether it's better to feel that you have something to be frightened of, even though you've probably blown it out of proportion, or whether it's just fear and you can't pinpoint any source—I don't know. I think that not to know what you're afraid of is a harder burden to bear, because you don't know what to grab at—you don't know what's going to comfort you. If you *know* the fear, you can *do* something to get away from it.

COR.: Maybe back then if they had had groups like ON OUR OWN, where people can talk about how they're having problems and about different ways of supporting each other and

that kind of thing . . . ? If you had had some support of that kind, not so much from your family but in another sort of caring or healing atmosphere—do you think it would have helped?

CAR.: I wasn't ready for that. I was too low for that. I mean I recognized when people were nice to me and wanted to talk to me, but I couldn't accept it. I just felt *alone*, totally alone with my problems. I felt nobody could solve them. In fact, after the shock treatment I was so askew that I didn't even know . . . I wasn't even aware that I had to get rid of any problems! The confusion was awful.

COR.: And that was after the three hours at home?

CAR.: Yes. I lasted three hours, and I phoned the doctor, and he said, "OK, I'll phone Selkirk (Psychiatric Hospital, near Winnipeg), and you get your husband to take you out." And that's exactly what happened.

COR.: Did you know anything about Selkirk at all?

CAR.: No, I'd never even been in Selkirk. The first thing I said when I saw the place was, "God—this place is *awful*!" The nurse who was with me, when she heard this, said kind of outraged, "What do you mean, 'This place is awful'?"

I will say that I recovered better in Selkirk, simply because it was a hospital that was a little bit more basic in your needs. It was very basic, in fact, but it gave you a sense of reality. You were looked after but you weren't pampered. You had a sense of the ground below you—it gave you an incentive: like you better fight, kid!

But one thing I do feel is that during my two-year stay in the hospital, it was the other patients that helped me come around more than actually talking to doctors or nurses . . .

COR.: So you had the shock treatments at St. Boniface, and then at Selkirk they started the insulin shock?

CAR.: Yes, I had nine months of insulin shock . . . All I remember is that about 5:30 or 6 in the morning they came around every Monday to Friday. They put a hypodermic in your arm with a lot of fluid. I got so used to them I wouldn't even bother

opening my eyes or looking up. And I knew I had to go into a deep coma, and I had to have so many deep comas before the therapy was finished. I always felt like I was in a deep coma when I'd come out of it. (They'd bring you out with another hypodermic of some solution.)

They did that five mornings a week for nine months, although a few days might have been missed—I can't remember.

COR.: And you gained weight?

CAR.: Yes, a lot of weight. You eat an awful lot; you have to drink glucose . . . I went into shock a couple of times but they forced glucose down me and I came out of it. I'd see other women go into shock—we'd just call the nurse. You get so that you're in a little world; it's your world there and you make the best of it. You learn. You're streetwise. I also had medication at the same time. A lot of medication: Librium, Stelazine—others. When I left the hospital, I was on about four or five different pills, and altogether I took about 18 pills a day. But it was gradually cut down and some were cut out. Now I'm on a very minimum dose—one and a half pills a day.

COR.: When you came out, were you still seeing someone?

CAR.: Oh, yes. I went back to Selkirk once every couple weeks or each month to see my doctor. I had a lady doctor whom I had an awful lot of respect for, and I believe my best interests were on her part.

PAT.: So you felt you could really talk to her?

CAR.: Well, some of the things she said to me are so very significant. Part of my problem was that I didn't believe that anybody understood me, so I wouldn't even listen that closely . . . That's probably why they gave me a lot of shock treatments: "We can't talk to her, so we better . . ."

I've said to my husband a couple of times, "You know, I knew I was breaking down. I knew I was. I should have walked away and left everything to save myself." I should have but I couldn't I was with my children. I felt duty-bound. I felt that to leave was an awful, awful thing to do, to leave—to leave your children or to leave your husband.



COR.: Before you actually had the breakdown, you were having these anxiety attacks and you were aware that there were things happening because of the anxiety and so on. Did you feel that because in part you were a woman, that you had the amount of pressures and all the work, all those kids, etc.—so you couldn't say, "I can't handle this"?

CAR.: But I couldn't verbalize. No, actually I shouldn't say that. I said once to my girlfriend, "I couldn't verbalize back then." Do you know what she said to me? "You could verbalize. Nobody would listen." That's the truth. Nobody would listen, because everything I did back then was a sign that I was breaking down. My husband said he knew. Do you know what he told me? He said, "I knew that you were breaking down two years before you broke down . . . But somebody had to look after the kids."

COR.: He was working full-time, and . . .

CAR.: He was a musician in the Army band at the time. His hours weren't long, and he was very good to look after the kids while I went to school, but he wasn't that good about wanting to do the housework or the dishes or the wash or keep the kids clean and so on. It wasn't because he was mean or anything like that. It was just because he didn't . . . I mean men's roles and women's roles were different then, and he felt he was going out of his way as a man even looking after the kids.

I think the whole thing was a misunderstanding.

PAT.: I don't know. I think there's a difference between men taking family responsibility—it's usually much more piecemeal.

CAR.: I was very impeccable, I was very much a perfectionist and like things right. I found I was using an immense amount of energy trying to make things right, which was stupid, because when I came out of the hospital, I was the worst slob in the world! But you know what? I realized when I came out of the hospital that when I did keep everything impeccable and spotless, I would get very upset if the kids would spill something or if the kids would drop some food down their front. And I thought the best thing to do was to let them create some mess. And if I don't worry about doing it, then I'm not going to worry about when it gets dirty! And that was better (laughing).

COR.: But you realize that was part of just being able to cope?

CAR.: I didn't want any more worries, and I wasn't going to worry about whether the tablecloth was clean or there was any dust under the chair. And I *didn't* worry about it, but I got a lot of criticism and flak on account of that from my husband and members of my family and people that would come to visit who would turn up their nose and probably go away talking. I didn't care. No, I can't say I didn't care: I felt guilty. But I also knew I couldn't handle it. I learned what I could handle, and I managed to raise five kids, because I got pregnant three months after I left Selkirk. I managed to raise five very active boys. I don't know whether it's my fault they all turned out well, but they all did turn out well. I wish I was as secure and knew myself as well as what my boys do now, when I was their age. I wish I did. I don't think any of them will see themselves in the position that I was in—they know themselves too well. And I feel that when I got married at 17, I had a very insecure upbringing. I was the least prepared of any 17-year-old girl to be a wife and mother.

COR.: Did you get married because you wanted to get out of the situation that you were in, or . . . ?

CAR.: No, I got married for one reason: I loved my husband and I wanted to be with the man I loved, and I didn't even have any plan or rhyme or reason for what was to follow. All I knew was that I wanted to be with the man I loved, and when I married him I bought the package. But the package—it didn't suit me, I didn't suit it. The "package," I mean, of being a mother inside with her little kids, looking very clean and proper, doing the right thing. And I just wasn't that type; I hadn't been raised that way. But you see, I gave into it, and that caused me a lot of distress, and worst of all, I lost the armour that I had built up to survive during those years until I got married. I

relinquished it which left me with no defense. I lost my edge and, believe me, no one should give up their edge.

I knew a woman who had four kids and was tired—she didn't break down. With me, it was a conflict. Like the way I was raised—I raised myself pretty well. I learned defence mechanisms, and I became very streetwise, but I wasn't really part of that very nice society out there that does everything the right way. I never got in trouble with the law or anything, but, I mean, Carol made her own rules, which *were* generally fairly moral and quite sensible—but were a little different from other people's. You see, when I got married, I let them go very quickly, because I thought, "Now I'm on the right side of the fence, I'd better be right, too"—but they *weren't* right.

PAT.: Yes, you adopt a model, wholesale, for security. But to do that is to give all your survival mechanisms up. I think it was the biggest mistake of my life, too.

CAR.: You know what it was—the same thing with you and me? We became dependent.

PAT.: Yes, I think I listened to others and let my own critical abilities sleep, just gave them up for awhile . . .

CAR.: I gave them up for a long time, because as a child, to get through a childhood raising yourself on your own for a good many years, you learn a lot of tricks. They work for you. And if you let them go, what have you got working for you? You are pretty defenseless. You see, when I was in the hospital I was a very confused young woman. Very confused. The last doctor I saw, I guess it was 9 or 10 years ago, read my case history over and said to me, "Carol, I'm very impressed with you. I'll tell you why. Very few people that were as sick as you ever made it back." That's what he told me.

PAT.: Sometimes I can't help, when I'm thinking it over, wondering about alternatives. What could have been done, instead. When I look back, I think that I took on too much, especially when I assumed a whole new, utterly new, model. And I shouldn't have abandoned my critical abilities so fast or so completely. But if the responsibility of the children had temporarily lifted *and if* I'd had understanding people to talk to to sort things out—then I wonder if that "breakdown" needed to happen . . . ?

CAR.: I feel exactly the same way.

PAT.: But it's a matter of society, individuals—whoever, picking up on it, picking up on it earlier and not just leaving you to do it all, yourself, and not, on the other hand, coming down on you with things that drive you, further . . .

CAR.: Yes, people to just talk to you and let you get it out, at least to say, "Well, listen, you ideas aren't so bad, you're not really crazy. What you're thinking is quite rational. It may not be what everybody usually thinks or says but there's nothing wrong with the way you're feeling. You have a reason to feel this way."

COR.: To make you feel that your reasons are valid—or even that you do have reasons at all. I know that when I went to see the very first psychiatrist that I ever saw, he sent me to have all those tests—association tests, etc. I felt that something must be really wrong, I must have some very serious problems or fears or I might have brain damage—I didn't know what. But afterwards when I thought about it, my God! You didn't need to be a psychiatrist to see that I had a whole bunch of problems.

I was 17 when I got pregnant for the first time. The man I was with was physically and emotionally violent. But I thought that because I was a woman I had to be really strong, I thought that because I had chosen to live with him at that age and to leave my parents—I had to take it all. I had to do the grocery shopping, I had to make the meals, and I had to take care of *his* ego, *his* emotional needs. I had been conditioned to accept this. And then when I became pregnant without really wanting kids yet, everyone around me said, "Well, of course you're going to have an abortion; you're not going to have the child." Even though I could imagine this nice little baby and loving it, I saw there was no way I was ready for that, so I just let my life be put into other

people's hands, friends and other people I knew who made these decisions for me—and I floated along. The breakdown came a few months after I had the abortion. I realized that I had no control over my life and saw all these things coming down on me. So I started to get really suicidal, and that's when I went to see the psychiatrist the first time and was given all those tests. I mean he never once said to me, "Well, after all, look at your situation: Of course, you might have problems . . ." It was always something in my psychological testing, there must be something there—something medically wrong. There was nothing *medically* wrong. It was just living . . . I mean—it was my life.

That psychiatrist sent me to a woman when he finally didn't want to deal with me anymore. And, again, her whole thing with me was that I should be able to handle that kind of stuff as a woman. I shouldn't be complaining that I didn't want to cook the guy's meals, or didn't want to take his violence when he was angry at the world or whatever. "That's your problem," she said, "You have to learn to cope with that, you know."

PAT.: It's awful, I can't help feeling, to notice how often it's the serious, well-meaning women who are trying to be responsible that this kind of thing happens to . . .

COR.: And yet the only "concern" that it seems the doctor had was to keep writing out the prescriptions! I mean one time I said, "Why aren't you talking to me more and finding out more about my problems instead? What are the pills doing? I mean, I am sleeping 18 hours a day on them! Why?" I started questioning what he was doing, and that's when he said he had too heavy a caseload and he was going to have to switch me (laughter).

CAR.: You realized that he thought what was important was the drug you were on . . .

COR.: I was aware that this wasn't right, but I still had been conditioned to believe that he, a psychiatrist, of course *knew*. He's God! I put all my faith in him. Anyone who's in any position in the medical profession—you just don't question these things.

CAR.: That's the point where we all make a mistake. It was 25 years ago when I had my breakdown, but it wasn't very long ago when this dawned on me: you have to help yourself. Because there really aren't that many people that are interested in you, other than clinically! I'm not saying they won't help you and support you, they will to a point. But when it gets down to the nitty-gritty, especially when you're being discharged from hospital and you're on your way up, you have to realize that it's up to you, that you do have to try and help yourself. I know there are a lot of patients out there who will probably read this in the magazine and say "Well, I can't help myself. I'm not capable of helping myself, so if nobody's going to help me—I'm finished." But it's not true, you *can* help yourself. Be patient. It's all struggle, for everybody.

And as I said to you the other day and to my husband the other night, "I believe that the world is an insane asylum for some other planet!" (Laughter) Really, I don't think I'm far wrong, because I don't think there's anybody who's . . . I don't even know *what* the definition of normalcy is. Is it when you don't create a disturbance on the street, and you don't dress too freaky, and maybe you conform a certain way to society? Is that what normality, and the so-called very normal have a way contradicted themselves it seems to me.

COR.: Do you think when you were seeing all the doctors and having shock treatments and drugs and so on that they were trying basically to make you "normal", trying to make you able to cope with the situation that you left?

CAR.: Yes, they wanted me to cope. I believe they didn't want to solve the problem of what happened. I believe they just wanted to get me to the point where I could cope. When I left hospital, for a good ten or twelve years I didn't reflect to much, because I guess it was too heavy to reflect on. But lately, the last four or five years, yes, I have been going back and trying to sort

it out—simply because I want to deal with it in my mind, and then to let it go and be free of it. I want to *learn* from it. I feel a lot of it was my own stupidity, my own indulgence, stupidity and childishness that used up all this energy and caused me all this anxiety and acting out. Like not so much violence but rather frustration, screaming confrontations and so on. I think we all are a bit childish and do stupid things. Let's not feel guilty or bad about it.

COR.: When did you think you were acting childish?

CAR.: For example, my husband would criticize me because, maybe, there was a piece of dirt on the floor, something like that, and I would start screaming and crying that he was no good. It was completely irrational. But you see, as a child the only way I was ever heard was if I screamed. My favorite act as a child—and this was a real attention-getter—was to lie stiff as a board on the streetcar tracks, and they would pick me up like a board and carry me out. But it got attention, it got attention! And that kind of attention is better than no attention, you see. I was a brat, and the only way I ever got anything was by being a brat and acting out and screaming or holding my breath. If I hadn't done these things I wouldn't have survived—I would have been completely ignored.

COR.: Were you an only child?

CAR.: No, I was the third child in the family. My father left when I was born, and my mother had to work. My mother wasn't a very secure woman, and she had to work very hard to support the three of us. My brother and sister are about eight and ten years older than I am, so I was like an only child. They've even told me, "You were left alone," alone in a house where there was no love. None. I don't dwell on it too much, a little bit, sometimes I indulge in self-pity, which is another ridiculous, stupid waste of time. But my sister phoned me one day a few years ago and said to me, "You know, we were cheated as children, but you know something? You were cheated worse than all of us." You see, it was the pattern of the way I grew up: I learned how to survive by being a brat. I could be a beautiful brat!

But I also suffered a lot of humiliation as a child. And I did feel very, very inadequate and very inferior. Then, I started the temper tantrum bit, which got their attention, because I really could have been swept to the wayside, I really could have been forgotten.

COR.: But then you went from that situation to just taking on a totally new one . . .

CAR.: Taking on a normal society, right? I remember when I was 11 or 12, I used to spend a lot of times being overnight at girlfriends' houses. I don't think anybody even knew where I was. Yeah, I'd go to the dance and I'd stay all night—that sort of thing. And I remember seeing the family, mother and father sitting by the table, and saying to myself, "Well, this is very nice . . . It's idealistic to see what a nice family is like. It's the way it should be."

But I could never conform to that at the age I was then, at 11 or 12, because I'd been on my own. I'd had that freedom, you see, and that's what I gave up when I got married. That freedom was very, very important to me and I gave it up.

COR.: There weren't a lot of alternatives back then for women, though?

CAR.: If I had known myself better and if I'd been more secure, I probably would have realized I was too young to get married. There's no reason why the relationship couldn't have continued without marriage until I was ready. Why make decisions after you've just turned 17 or so? I don't know what happened. Sometimes I think maybe I wanted a drastic change, or maybe I wanted to have a nice little house with a nice little car and all the nice little things. When I bought them, I couldn't stand them, I couldn't feel comfortable with them. I still wanted to be free. When I saw my girlfriends going down the street with their boyfriends to the school dances, I was sitting there with one baby and another on the way, and trying to cook dinner and keep a

house clean. I felt an awful longing. I felt like my life was over.

COR.: Did your husband understand how hard it was?

CAR.: Yes. You know what my husband tells me now? Understand, my husband came from the opposite type family. His father was a policeman, and he had a very tight-knit family. They were very strong conformists to society, to the law and right and wrong. And my husband had this awful sense of right and wrong. He used to inflict it on me, and often since he has said to me, "Carol, you know when you married me? You should have run."

COR.: Do you think that you'd ever have a nervous breakdown again?

CAR.: I know myself well enough now. I know the danger signals, and I know what to do for them. Sometimes I feel a little out on the limb. Sometimes I get bouts where I get very temperamental and I get angry with my husband and all that, but I have control to a certain extent. I'm more detached than I was. Back then I was very emotionally involved with everything. I took everything very deeply.

COR.: Did you ever go to a support group? You and your husband have a very close relationship now and help each other, but if you didn't have that, would you . . . ?

CAR.: If I didn't have my husband for support, I feel I would need a close friend. I'm not crazy about being in groups. It doesn't fit my personality, but I think it's a good thing for a lot of people: there's a lot that do enjoy it. But I'm very comfortable with a one-to-one.

Certainly, I feel I would need somebody that I was able to talk to. If that somebody were a psychiatrist, that's OK. If the somebody was a layman, then fine, as long as I felt the person really understood. Actually, the thing I need in my life more than talking with somebody in the area of my problems: I need to be active. I like to walk, I like to swim, I like to ski, I like to participate to a certain extent—and I like a reasonably balanced day. If I do all those things, I find it keeps me at a pretty reasonable even keel.

COR.: So now, you've learned how to live in a way which you can cope, on your own . . .

CAR.: Certainly. I don't take anything I can't cope with, unless it's something I have control over.

COR.: Well, you've learned a lot!

PAT.: You were talking about the importance of knowing yourself. Perhaps it's rather judgmental, but do you feel maybe that you have learned about yourself to a greater degree *through all this* than you might have otherwise, or than other people do?

CAR.: With the help of my husband. Our relationship is not 100% but it's a good 80%. He's my best friend, so we have a good relationship in practically every way. It's a mystery. Like I told you the other day, anybody that believes that life is not mysterious or awesome, I'd like to talk with them. It is, it is a mystery and it is awesome. I believe that men's horizons are unlimited. I believe the creative force is almost unlimited and it's a matter of tapping into it. I feel I've tapped into it a smidgen with my art. I want to tap into it more—it's very important to me.

COR.: Is your art really a contributing factor in your getting well again, too?

CAR.: It was a desire that never left me. I can't say that when I was in the hospital and under the influence of shock treatments and drugs and had lost my memory that I even thought of it. But although I wasn't conscious of it, my desire to paint and to draw and to create never left me. My creative life is painting. I've done about 350 or 400 paintings, which isn't a lot over 25 years. It's just something I find necessary. I'm not really out to impress anybody. Criticism doesn't bother me—I'm happy to hear anybody's criticism, whether it's good or bad. And I've never felt jealous or envious of anybody that's better—and there are people that are better, of course—they're much better. Because I like to see good art, and I like to see people do well, so

when I see people doing better, really doing well—I enjoy it. I don't feel threatened. I feel there's a place for me, but it's never discouraged me ever from painting to see somebody better. In fact, it encourages me.

I just feel very comfortable painting. It's part of my life and has been for a long time.

PAT.: You were saying before about being uncomfortable somewhat . . .

CAR.: I feel medication is a sedation. And I think there are times in your life when you need that sedation. I mean just to keep you from harming yourself or anybody else or just to keep you from being in hell. You know, to calm down. But I think the long use of drugs—I feel that it kills your spirit. And I think that you have to have your spirit, that's what keeps you going, it's what makes life interesting and exciting and peaceful. Everything that life involves is your spirit. Like if a person has a very depressing feeling and becomes aware of it. It dawns on you, "Hey, wait a minute. My spirit isn't what it should be." Sometimes you compare it, the way you thought before to the way you feel now. Years later, you think, "Uh-oh, uh-oh. I don't like that." Now, as I told you, I'm on a very minimum dose. I feel super since it's been cut down, because I feel the spirit reviving. And I'll tell you something: For years, there was no light at the end of the tunnel for me. Now, I see a light at the end of the tunnel, and I ain't letting go for nobody. So there, you know!

COR.: And you're still gradually getting off of your medication . . .

CAR.: Yeah. I'm not hurrying it, I'm not rushing it. I think too many things are done in haste. I mean that's another qualm I have of society today is what the hell is all the rush for? I mean, is the world going to fall apart if the pace slows down a little bit? Why *should* people be expected to work under pressure? And I see these ads in the paper, these jobs that say, "Must work well under pressure." Well, what right have they got to inflict pressure on anybody? Sure, the person will last under pressure—for 6 months. And then they'll burn out. And then the boss will just hire somebody new, so the person's ignorant or a fool or the boss is a fool—or they're both fools. Who's got the right to inflict that on somebody else?

COR.: Yes, there's the whole idea of having to handle pressure. A lot of people that I know have had experiences of a breakdown of one sort or another, then going into a hospital or seeing a psychiatrist, and the whole thing of trying to get you "normal" again, trying to get you to cope with life, instead of maybe questioning the way life is and what's happening. Instead of questioning the fact that people don't *want* to work under pressure, people don't *want* to handle such situations.

In other words, they're setting up standards for us—they're telling us how we have to be, or else we're inadequate. Or else get something else that's for weaklings. I know a lot of people just within our group (On Our Own) end up in hospital, not just once but a number of times. A lot of them I've seen over the years: they come out of the hospital, they're caught up in a situation, and they immediately think what they've got to do is get back into the mainstream and cope with all that pressure and . . .

CAR.: They think that'll prove they're OK if they can handle that . . .

COR.: Sure.

CAR.: That's not a measuring stick.

COR.: No. Also a lot of people have to deal with this whole question of, "Well, what should I put on an application? If they find out that I've been a mental patient, I'll never get the job." And employers respond, "Oh, they've had a psychiatric history. They won't be able to handle pressure." They psychiatric profession which is supposedly healing and helping us cope with life—but they never say, "Maybe the world . . . ?"

CAR.: They set up standards for us and we don't question them.

PAT.: It's short-circuiting that very process of learning about yourself, and learning about the world around you.

CAR.: Yes. Oftentimes, I've heard people say to me, "Do you have any idea now that your kids are grown up what you want to do or be?" And I say, "No, I don't have any idea of what I want to do or be, but I know how I want to feel. And I know when I feel that way, and I sort of start examining what steps make me feel that way." I don't demand a whole lot. My needs are very simple.

PAT.: I don't think it's any accident that you've got five fine sons!

CAR.: Thank you . . . They've had problems, and they've handled them half-decently. They seem reasonably together and reasonably whole and that makes me so happy. I'd be so worried if they weren't, you know, but they are.

COR.: It's a close family?

CAR.: Yes. They're all very loyal to each other, even though they're very different . . .

COR.: Well, I think you have a lot to be proud of in yourself.

CAR.: I marvel at people I see. I see a lot of their stupidities because I see them in myself. You learn somehow. But as I say, I now can see the light at the end of the tunnel, and I'm not planning on letting go. It took me too long to get it. But I do have a feeling that there is a superior power. I do have a lot of faith in it, I feel the energy from it. But I feel that we given the power to make a lot of the decisions ourselves.

COR.: Yes, and the responsibility . . .

CAR.: Yes, that's exactly right. We have been given some responsibility.

PAT.: And a lot of that is surely to know who we are and not to submerge ourselves, not be something we aren't . . . ?

CAR.: I guess the whole thing boils down to the fact that we have to heighten our awareness, to be able to see . . .

COR.: And a lot of people seem to go through life without even realizing that, without ever tapping into that. I remember your talking last time about how you see the tombstones in some people's eyes!

CAR.: But they can sometimes surprise you! If you actually get along with some of these people and you talk with them, you'll be very surprised that they feel a lot, the same way you feel; they think similar things, but they have a different way of coping with it. What works for one person doesn't always work for another.

Do you know what I was conscious of when I was raising my children? Allowing them their freedom. I did, I allowed it. I didn't want to kill their spirit. Also, I didn't want them to have the humiliation or torment that I felt as a child. But I did want them to feel freedom and abandonment as a child, and they still carry it with them. I think that's one of the reasons they're rea-

sonably happy. See, I had that freedom and abandonment as a child by having to raise my self, but I always thought that people that lived their little, tight-knit little lives were the right ones.

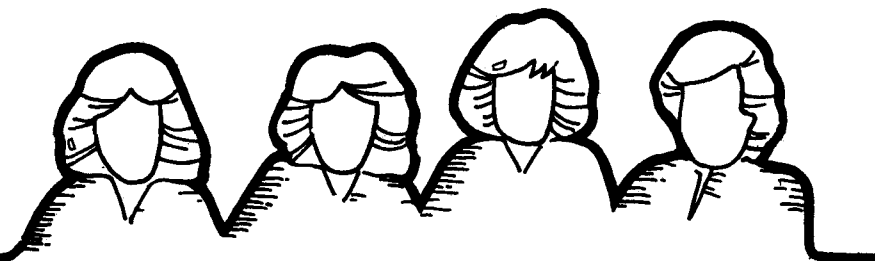
Nobody told me, "You're bright, Carol, you're going to be an artist!" I always thought that I was wrong, because we were criticized, our family, we were very gypsy-like, we moved every month—all that nonsense.

You know, everybody's got a good story. Everybody has. I love to see people's stories, as long as they're not too dull. And I like to hear successful stories. I don't care what leads up to the success—I always feel good if somebody comes out the other end in one piece. I feel good, I like that. I feel bad if they don't. But you can't take the troubles of the world on your shoulders. You have to be detached to a certain extent, because it'll overwhelm you, the problems of the world—it'll get you.

PAT.: I was quite struck by some themes in your poetry. The sense of freedom and abandonment that you write of is something I feel I've had to strive for all my life. I feel I was *too* serious. I *had* to be serious to survive—I wasn't supported—but then I took everything on and that became self-destructive in turn. Then the most important thing to learn—still is—was to lighten up . . .

CAR.: Yes, there is self-indulgence—in being too serious. Everybody has an indulgence of some kind. Some people indulge terribly in self-pity. Some people indulge terribly in their self-importance—they can't forget themselves for a minute. We've got to get over that and start looking outward and instead of inward all the time. One of the things that has pulled me through is I have a bit of a sense of humor. It's helped. Sometimes I am so devastated by something that has happened that I get to the point—it's either laugh or cry. I usually laugh.

Women carry a burden. But you know, I've never regretted being a woman. As a matter of fact, I've never really thought of myself so much as a woman. I just think of myself as a person. When I'm talking to men or women, I don't really think of talking to a woman or a man—they're just spirits or people. I only really think of people as being men or women or children when I immediately meet them unaware. But when I get talking with somebody, their identity leaves—they're a spirit or a person. And I always figure they feel that way about me. I think that somebody that looks at me as a woman is narrowing me; they put me in a very tiny little slot. I would rather be looked at as a person, because that's broader than being categorized as a woman. I think women are great—I've never regretted being a woman. I think it's been an advantage. I'm not formally a women's libber by any means, but I believe in nearly everything they say. For myself, though, I have felt that the only thing I've had to be liberated from is my own stupidity.





the Book worm turns

DR. CALIGARI'S PSYCHIATRIC DRUGS

by Network Against Psychiatric Assault
Berkeley, CA: NAPA, 1984, 65 pp.,
paper, \$4.50

Reviewed by
DON WEITZ

This small but potent booklet on psychiatric drugs is a very important contribution to the continuing drug education of psychiatric inmates, ex-inmates, health professionals, and the general public. The work is the third drug book published by the Network Against Psychiatric Assault (NAPA) in California, one of the most respected and outstanding anti-psychiatry groups in North America. The current edition is a greatly expanded and much improved version of two previous ones published in 1978 and 1976.

Although the booklet is largely written by Dr. David Richman ("Dr. Caligari"), a practicing physician in Berkeley, California who writes an outstanding drug column in *Madness Network News*, it's really a collective effort of several NAPA members, all ex-psychiatric inmates. This booklet can proudly take its place alongside psychiatrist Peter Breggin's impressively researched *Psychiatric Drugs: Hazards to the Brain* (Springer 1983).

There are at least three distinguishing features of *Dr. Caligari's Psychiatric Drugs* which separate it from most "consumer-oriented" drug books. One is its use of plain everyday English, which is refreshingly free of medical-psychiatric jargon. For example, the common and generally permanent, drug-caused neurological disorder of tardive dyskinesia is defined: "... *tardive* means late-appearing, because it usually takes 2 or more years of neuroleptic use to produce this condition. *Dyskinesia* means abnormal muscle movement." And *neuroleptic* literally means "nerve seizing." Breggin also correctly re-labels the "major tranquilizers" and "antidepressants" as *neurotoxic*, a more accurate and less mystifying term.

A second major feature is the booklet's layout. It's an eye-catching, conscious-

ness-raising mosaic of large easy-to-read print spread out over two columns on each page, with dramatic illustrations, powerful personal statements by ex-psychiatric inmates, obscene and sexist drug ads which condemn themselves and the drug companies, a useful bibliography, and a partial list of antipsychiatry groups. The front cover is a blow-up in black and grey of some adverse reactions (tardive dyskinesia and death) excerpted from the *Physician's Desk Reference*.

In addition, sections on the drugs' frequent, occasional, and rare effects (not "side effects") are clearly highlighted in each of nine chapters which deal with the drugs themselves. Each chapter has a "Special Precautions" section; there's also a separate chapter on "General Precautions" which includes some alarming information on the many drug-caused sexual disorders affecting men and women. Further, each chapter lists low and high adult dosages for all the drugs.

A third outstanding feature is the book's upfront educational and political positions. In chapter 1 ("Getting Drugged"), Dr. Caligari tells us that the main reason for publishing the book is to:

educate all those involved with these drugs, including people getting or thinking of taking them, concerned family and friends and health care workers. Reliable information about drug effects, toxic effects and medical complications is crucial to ensuring a truly informed consent.

However, in chapter Two ("Consent and Coercion"), we learn that free and informed consent to drugs, electroshock or any other "treatment" is virtually impossible in a psychiatric facility. That's because psychiatrists and other doctors tell us little, if anything, about the drugs prescribed for us, such as dosage and health risks including seizures, tardive dyskinesia or brain damage. Psychiatric staff also frequently threaten "difficult" or "uncooperative" inmates with forced megadose injections if they refuse or try to refuse the "medication." So much for "consent." (See the SmithKline drug ad: "WARNING! MENTAL PATIENTS ARE NOTORIOUS DRUG EVADERS" on p.9).

Dr. Caligari also attacks the traditional psychiatric myth of "mental illness" and its "supposed chemical origins" including the mythical "chemical imbalance" and dopamine speculations (usually misrepresented as facts), which psychiatrists frequently cite to justify heavy drugging of people labeled "schizophrenic", "manic-depressive" or "psychotic". The neuroleptics—such as Thorazine, Stelazine, Mellaril, Haldol and Moditen/Modicate (Prolixin in the U.S.)—and the antidepressants—such as Elavil and Tofranil—are all brain-damaging, even at moderate or "therapeutic" dosage. Together with electroshock, these chemical lobotomies are psychiatry's favourite weapons of social-control, used to crush cultural dissidence and non-conformist people (not just in the Soviet Union).

The nine chapters on the drugs themselves cover the neuroleptics, antidepressants, anti-parkinsonian drugs (such as Cogentin and Kemadrin which cause their own serious reactions), lithium (toxic even at "therapeutic" or "maintenance" dosage), anti-anxiety drugs ("minor tranquilizers" such as Valium), psychostimulants (amphetamines or "speed"), geriatric and miscellaneous drugs including the high-risk "premedication" given before electroshock. For example, Brevital, a short-acting barbiturate, raises the seizure threshold so that more electricity is delivered to the brain. And Anectine, or succinylcholine, a "muscle relaxant", stops *all* breathing and paralyzes the whole body during each shock treatment.

While reading this booklet, I felt sad and angry. Sad and angry knowing that literally millions of people are being brain-damaged by "tranquilizers" and "antidepressants" which neither tranquilize nor combat depression, but deaden bodies, anesthetize feelings, and crush the spirit. Sad and angry learning that people on lithium are being poisoned. Sad and angry realizing that the dangers of addiction to and withdrawal from Valium and other "minor tranquilizers" are rarely explained to people, especially to women and the elderly. Sad and angry knowing that all too many physicians practice polypharmacy (prescribing two or more drugs simultaneously), which greatly increases the risks of addiction,

overdosing, and death. Sad and angry knowing that many brothers and sisters are being conned or coerced into taking these drugs for their "own benefit" or "best interests".

Nevertheless, people can free themselves from these chemical straitjackets. Chapter Fifteen on "Drug Withdrawal" is an excellent, responsibly written and long-overdue article which should be widely read and studied. It informs the reader how people can *gradually and safely* withdraw by following a recommended "10% formula"—the drug is reduced in small steps over weeks or months until total withdrawal is achieved. Sudden withdrawal or "cold turkey" is definitely discouraged because it can cause many serious reactions and thereby force people to seek hospitalization. Safe and supportive detoxification houses are urgently needed for people who've decided to get off these psychiatric drugs, but few, if any, exist in Canada or the United States.

Two minor criticisms of this fine booklet. One is that little attention is given to special drug risks for children, pregnant women and the elderly who are the most vulnerable. Also missing is a special section or chapter on drug-related deaths and their coverups, which would have added to the booklet's political impact.

Dr. Caligari's Psychiatric Drugs is so outstanding that it deserves to be widely read and treasured as a people's manual to psychiatric drugs. I strongly recommend this drug book for everyone, including those mental health professionals who still believe that these drugs are "safe and effective medication." In fact, they're chemical bullets, used in a game of psychiatric Russian Roulette. Psychiatric drugs should be labeled clearly as a **HEALTH HAZARD** and declared **UNCONSTITUTIONAL**, since they're both a direct threat to the life, liberty and security of the person, and a form of cruel and unusual punishment—not "treatment."

NOTE: One copy of *Dr. Caligari's Psychiatric Drugs* costs \$4.50 (postpaid, U.S.); 5 or more copies cost \$2.50 each (postpaid). Copies can be ordered by writing to: *Network Against Psychiatric Assault*, 2054 University Avenue, Berkeley, CA. 94704.

The Politics of Schizophrenia: Psychiatric Oppression in the U.S. By David Hill

500 pages
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ANNOUNCEMENT

New Book Coming Out on Psychiatric Atrocities

Lenny Lapon, an ex-inmate activist and writer, is soon to publish his own book entitled Mass Murders in White Coats: Psychiatric Genocide in Nazi Germany and the United States. Since Lenny is trying to raise money to print his book, he'd greatly appreciate any donation that you can make. The book sells for \$7 (US, including postage and packaging). To order copies, please write to: Lenny Lapon, 339 School Street, Athol, MA 01331, USA. Thanks for whatever support you may be able to give Lenny for his important book.

THIS NEW BOOKLET COULD CHANGE YOUR LIFE OR THE LIFE OF SOMEONE YOU CARE about. *Dr. Caligari's Psychiatric Drugs* is the most thorough, easy-to-understand, and reasonably priced guide to psychiatry's mind/body control drugs available today. Drugs like Haldol, Prolixin, Thorazine, Elavil, lithium, and Valium are used regularly by an estimated 35 million people in the U.S. alone. Rarely is genuine informed consent obtained from them: in addition, many are drugged against their will. Critics charge that these are serious human-rights violations. Written by Berkeley physician David L. Richman, the booklet details the damaging, often devastating, effects psychiatric drugs can cause; discusses various political, social and corporate aspects of their use; and offers suggestions on how to withdraw from them.

Dr. Caligari's Psychiatric Drugs is 61 pages, 8½" × 11", illustrated. The single copy price is \$3.50, plus \$1.00 postage. Orders of 5 or more are \$2.50 per copy, postpaid. Send check (payable to the Network Against Psychiatric Assault) to NAPA, 2054 University Ave., Berkeley, CA 94704.



Ontario Coalition To Stop Electroshock: UPDATE

By Brian McKinnon and Don Weitz

(Ed Note: Brian and Don are members of the Coalition)

The Ontario Coalition to Stop Electroshock has come a long way since its founding in August, 1983. Its membership now includes roughly one hundred individuals and seven community and self-help groups such as ON OUR OWN, S.P.R.E.D. in Hamilton, and Auto-Psy in Quebec.

Although snubbed by the Ministry of Health, the Coalition has been very active and effective since its first anti-shock public demonstration in front of the Clarke Institute of Psychiatry (Ontario's 'shock shop') on October 22nd, 1983 the first North American Day of Protest Against Electroshock. This brief account is testimony to what can be achieved by a small but dedicated group of individuals who speak with one voice: **NO MORE SHOCK!**

As described in a recent article on shock ("History of a Medical Scandal," *Phoenix Rising*, April 1984), a significant turning point in our struggle to outlaw shock occurred on January 17th last year, when the Toronto Board of Health supported the Coalition's request that it take a public stand against this brain-damaging, psychiatric procedure. After the Board heard statements from seven Coalition members and three shock doctors, it promptly passed a motion calling for an immediate moratorium on electroshock without free and informed consent, pending public hearings, more research, and consultation with the Coalition. This was the first time in Canada that a board of health had recommended a restriction on shock. We were greatly encouraged and thanked the Board for its courage.

Health Minister Keith Norton's response to the Board's motion was swift. The next day, January 18th, Norton announced his intention to appoint an "international panel of experts" to investigate "ECT" in Ontario. He added that he was "troubled" by the fact that shock was still being administered without consent. From this point on, however, Norton became ominously silent and invisible on the issue of shock and consumer representation on his new "Electroconvulsive Therapy Review Committee."

During the next five months, Norton stubbornly refused to answer numerous letters and phone calls from the Coalition. We requested Norton's personal assurance of consumer representation on the ECT Committee; his specific response to the Board's motion for a moratorium; and his support of public hearings on the issue. In fact, there was only one response from the Ministry. That was a letter, last April, from Deputy Minister Boyd Suttie to Coalition member Dr. Bonnie Burstow, in which Suttie promised that chairman Charles Clark would contact her shortly. He never did.

By the end of June—five months after Norton had promised action—it was clear that the Coalition would be denied representation on the committee. At the same time, numerous

health, legal, and academic bodies had been asked to submit the names of committee nominees to the Ministry, but the Coalition was not granted this courtesy. Though ON OUR OWN, one of the only two self-help groups contacted, recommended lawyer Carla McKague and psychotherapist Bonnie Burstow, neither was contacted. The obvious conclusion to be drawn was that the ministry had an anti-consumer bias. The psychiatrized had to be ruled out.

After having exhausted all the proper channels of communication with the Ministry, and fed up with the usual bureaucratic runaround, the Coalition decided to act. It decided to lay peaceful siege to the Ministry's doorstep, and to mobilize public support through picketing, leafleting, and the media.

On the morning of July 3, with the solid backing of many supporters, Coalition members Shirley Johnson, Bonnie Burstow, and Don Weitz made an unannounced visit to Mr. Norton's office. They were determined to meet with Norton and to remain in the reception space until he met with them. Shortly before the visit, all three had brief training in non-violent civil disobedience.

As expected, Norton's aides promptly informed the three visitors that he was "not available," and so the drama unfolded. As the hours passed, Norton's aides tried to appease our peaceful visitors and pressure them to leave, but they stood firm. The media turned out in force, contributing to the scene of creative chaos on the 10th floor of the Hepburn Block. By 5 o'clock that afternoon, the three were forcibly escorted from Norton's office by the government's security guards. The same scene was played out the next day. On the third day, when they arrived outside Norton's office, our Coalition representatives were told by the guards that they were "not wanted." The door to Norton's reception area was locked and heavily guarded. Within minutes, the three were forcibly evicted from the building.

Throughout the 3-day "sit-in", the Coalition also issued a flurry of press releases, one of which was a response to Norton's press statement, stating that "as a matter of principle" he did not meet with people "who resort to pressure tactics, such as sit-ins."

A few hours after the final eviction, the Coalition held a press conference at City Hall denouncing Norton's arrogant refusal to meet with us, and demanding that Norton start living up to his alleged concern for shock survivors by calling a moratorium on shock. Of course, he didn't. On July 6, with only 24-hour advance notice, the Coalition organized a small but vocal protest demonstration in front of the Legislative Building at Queen's Park. Thirty supporters turned out. Some people, including Shirley, Bonnie, Don, Coalition chairperson Hugh Tapping, prison abolitionist Ruth Morris and Richard Johnston (an NDP Member of the Ontario Legislature) made strong anti-shock statements and condemned the absence of shock survivors on Norton's ECT Committee. Our spirits were high, despite the presence of nine police and security guards who saw us peaceful demonstrators as a security threat.

As a consciousness-raising follow-up, during the next two weeks several Coalition members handed out over two thousand anti-shock leaflets to civil service workers and the public on downtown street corners, including Bay and Wellesley where Norton's office is located.

When Norton finally announced his ECT Committee on July 23 in a press release, he did not mention a moratorium. He also did not mention consumers or shock victims, who were conspicuously missing on the list of the fourteen appointees, most of whom are mental health professionals. The final insult was Norton's appointment of two shock advocates, psychiatrists Emil Zamora and Paul Hoaken. In response to the Coalition's condemnation of these appointees, Norton remarked that these "psychiatrists" will be objective scientists when they participate in a provincial review" of ECT. Mr.

Norton must have a low opinion of the Coalition's and the public's intelligence if he believes that people can trust the "objectivity" of psychiatrists such as Dr. Zamora who administers shock and has publicly stated that "ECT is a safe and effective treatment."

Another sore point was Norton's misrepresentation, in fact distortion, of ON OUR OWN's recommendations. ON OUR OWN recommended Carla McKague and/or Bonnie Burstow as the group's *primary choice(s)*. As a "supplementary possibility"—and only that—ON OUR OWN's clear directive,

Norton appointed Kunov and misleadingly named him as ON OUR OWN's nominee to the committee. However, because of strong criticisms concerning the committee's lack of consumers voiced by several groups and individuals, Norton recently added Carla to the committee. Although we're proud of Carla and know she'll be a strong consumer rep, she's the *only* shock survivor on the 15-member ECT Committee.

The Coalition continues to earn credibility and respect from an increasing number of shock victims and other ex-psychiatric inmates, community and advocacy groups, boards of health, the media, and the general public. On July 20, the board reaffirmed its motion (the third time in six months) calling for an immediate moratorium on electroshock without free and informed consent. At the same time, it also released a major brief which admits that shock's clinical risks are greater and benefits are less than what are generally reported in the medical literature—a conclusion which partly supports the Coalition's position.

More recently, on August 25, about 15 Coalition members and supporters carried out a successful public demonstration in front of St. Joseph's Hospital in Hamilton to protest Dr. Zamora's advocacy and use of shock at that hospital, and his presence on the ECT Committee.

It has been nine months since Keith Norton announced his plan to set up a committee to investigate electroshock in Ontario. During this period, approximately 15,000 shocks have been inflicted on almost 2,000 people. The fact that these figures are perceived by the Ministry as only statistics, and not brain-damaging psychiatric atrocities, is made evident by the long time it has taken the ECT Committee to constitute itself, and by its exclusion of the public and media. This is a good example of how the Ontario Government, with the help of the medical-psychiatric establishment, frustrates public health education and blocks political action that challenges psychiatric "treatments" such as electroshock.

Another sore point was Norton's misrepresentation, in fact distortion, of ON OUR OWN's recommendations. ON OUR OWN recommended Carla McKague and/or Bonnie Burstow as the group's *primary choices*. As a "supplementary possibility"—and only that—ON OUR OWN added the name of Hans Kunov, a professor of electrical and biomedical engineering at U of T, who is an expert on the effects of electricity on living tissue. Completely ignoring ON OUR OWN's clear directive, Norton appointed Kunov and misleadingly named him as ON OUR OWN's nominee to the committee. However, because of strong criticism concerning the committee's lack of consumers voiced by several groups and individuals, Norton recently added Carla to the committee. Although we're proud of Carla and know she'll be a strong consumer representative, she's the *only* shock survivor on the 16-member ECT Committee.

SHOCK COALITION PUBLIC HEARINGS

The Ontario Coalition to Stop Electroshock held a series of public hearings on October 13, 20, and 27 at City Hall. The Coalition decided to hold these hearings because: 1) Norton and the committee have refused to hold public hearings (only written submissions will be accepted); 2) Norton has refused to appoint consumers or shock survivors (except for ON OUR OWN member—lawyer Carla McKague) to the 16-member committee; and 3) the ECT Committee has a strong medical-psychiatric bias—two shock doctors sit on the committee.

The Coalition has serious doubts about this committee's ability to address the many real concerns of the psychiatricized, especially shock survivors. In organizing its own hearings, the Coalition will ensure that the experiences and testimony of shock survivors and concerned members of the public will be heard and taken seriously. Excerpts from the personal testimony of shock survivors and other concerned citizens will be published in the next issue of *Phoenix Rising*.

The complete series of unedited testimony is now being transcribed, and will be sent to the Ontario Government's Electroconvulsive Therapy Review Committee. Copies of Coalition submissions can be obtained by writing to:

Charles J. Clark, Q.C.
Chairman
Electro-convulsive Therapy Review Committee
101 Bloor Street West
14th Floor
Toronto, Ontario
M5G 1P7

We urge all shock victims and other concerned people to join us in our continuing struggle against shock. For more information, please call us at: (416) 864-1940 or, write to:

Ontario Coalition to Stop Electroshock
Box 7251
Station A
Toronto, Ontario
M5W 1X9



Women And Psychiatric Drugs

Editorial Note: The following excerpt is taken from a booklet entitled *Dr. Caligari's Psychiatric Drugs*. *Dr. Caligari* is the pen name for David L. Richman, a physician practicing in California. We thank the Network Against Psychiatric Assault (NAPA) for their permission to print this excerpt.

See "The Bookworm Turns" for Don Weitz's review of *Dr. Caligari's Psychiatric Drugs*.

General Precautions

- 1) Reduction or elimination of sexual interest, drive, and of the ability to become sexually aroused, including lessened sensitivity of the erogenous zones.
- 2) Reduction or elimination of normal vaginal lubrication with sexual arousal, which can lead to painful attempts at intercourse.
- 3) Vaginismus (unusual tightening or spasm of the vaginal muscles, which can make intercourse painful, difficult, or impossible).
- 4) Reduction or elimination of orgasms.

SPECIAL NOTE: Psychiatric drugs, especially the major depressants, can interfere with normal fertility in both women and men. To date, there has been little research in this area.

Drug EFFECTS ON MENSTRUATION.

Normal menstrual cycles involve the clock-like coordination of the brain, pituitary gland, ovaries, uterus, and the whole body. Various factors can interfere with menstrual cycles including psychological state and stress, strenuous physical activity, pregnancy, gynecological and hormonal problems, birth control pills and other drugs. Psychiatric drugs, especially neuroleptics and anti-depressants, can also effect menstrual cycles. Potential problems include:

- Irregular menstrual cycles.
- Changes in patterns of menstruation, (e.g., duration and blood flow).
- Complete cessation of periods (amenorrhea).

It is important to remember that pregnancy should always be considered as a possible cause of menstrual changes. Active heterosexual women who are taking psychiatric drugs should undergo a pregnancy test (preferably a blood test, for accuracy) whenever menstrual irregularity becomes of sufficient concern. In this way, pregnancies can be immediately identified and the drug effects on developing fetuses minimized by eliminating psychiatric drug intake. In a related issue, birth control pills, aside from their other dangers (e.g., blood clots) can affect psychiatric drug levels. As an example, taking birth control pills with Valium tends to raise Valium levels in the blood, thus increasing their effects. Physicians

should be notified about the combined use of any psychiatric drugs and birth control pills.

Pregnancy, delivery and breast feeding pose particular risks. Pregnant women and women planning to become pregnant should avoid psychiatric drugs. Pregnant women who are taking these drugs should seriously consider withdrawing from them (see chapter on Withdrawal, p.54). Psychiatric drugs taken during pregnancy increase risks for mother and unborn child alike. Without naming specific drug categories, here are some of the potential problems: miscarriages and spontaneous abortions are more common; pregnancy, labour and delivery are more dangerous; these drugs can cause birth defects, e.g., webbed feet, cleft palate and heart abnormalities. The relationship between the use of these drugs and mental retardation has not been established. Even more uncertain and complex is the relationship between the use of these drugs and what is now called behaviour teratogenesis (BT). BT refers to abnormalities in behaviour caused by subtle damage to the brain resulting from drug exposure in the womb. In addition, babies born of mothers taking depressant drugs tend to be lethargic, have breathing and feeding difficulties, muscular problems and reduced ability to bond with parents. Infants can also suffer drug withdrawal reactions after delivery. These can occur hours, days or weeks after delivery. Psychiatric drugs can not only be passed from mother to child in utero, but also through the milk while nursing. For this reason, women on these drugs should not breast-feed their children.

After hundreds of days locked up she's free, a scared woman, enough pills in her purse for 100 suicides, a total dependency on the shrink who by this time is plaguing her sexual innuendo and she is so lonely for a friend she can't stand it. And she can't think and wonders how she used to remember things and speak her mind. She's quiet now, reads cookbooks and she's very much into drugs. She's lonely, meets a man, gets married—the shrink and husband shake hands, therapy over, she's cured. Still lonely, she has a baby, a baby born of a momma force-fed drugs, born with fingers and toes webbed and the momma thinks, "thank God that's all." She knew, like women in Viet Nam know—our children are being poisoned by white men. Men have always feared our wombs and the power of birth. And the pills, Stelazine, Thorazine, Prolixin—they are money, they are power, they are death. In giving up the pills I no longer identified with sickness. My long struggle for rebirth began.

Ahni, in MADNESS NETWORK NEWS, Vol. 3, No.6, 1976, p.4.

OUT OF THE ASHES

... FEATURES, POEMS, PROSE, GRAPHICS, PHOTOGRAPHS—writing or artistry of any kind by anyone who has been psychiatrized.

Day Room

Shallow sighs
of
Pale
green
walls—

No frantic
incantations

A
fit
upon a concret

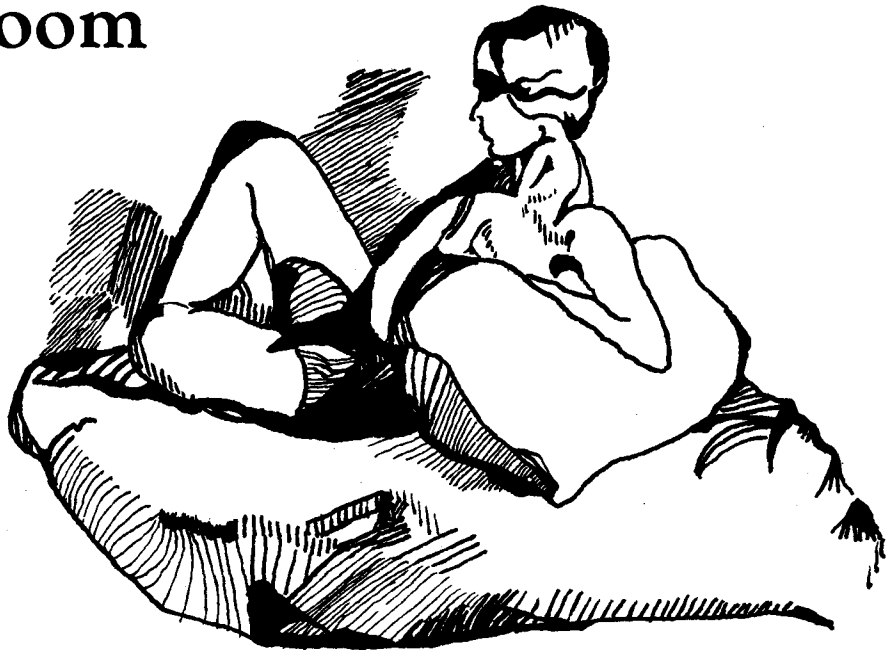
A
fit
upon a concrete
floor—

a madwoman's
ballet

In
darkened rooms
on any
afternoon
(no fanfare . . .)
just—

some pantomimed
obscenities

performed
for
free



Nira/84

Forget Us Not

He
calls you
Afraid
Saying "Speak"
Saying "Fear death by silence"
Saying all of this as you crawl
Clutching your secrets between
Clean
Green
Walls
Where colours and maps and rhymes
fall
like petals of
crazed
forget-me-nots

by Nira Fleischmann

Nira Fleischmann

Ward Thirteen

the ward-aid used to
ring a bell at
mealtimes.
she would stand at the very end of the hall, by the
door, and ring the bell.
there wasn't much point to it really, because we'd all
been waiting for it.
had all been sitting on our beds,
in various postures of waiting.
and we'd all seen her set out from the
nursing station, had all been aware of her going
down the hall
toward the door
and we all knew that it was Time for
the bell, the trek, dinner.

but even if there was no point to the bell, we all
waited for it anyway.
and when it rang, we all
slid down off our beds and shuffled mutely down the hall,
to the door, like cattle
on their way to the barn.

i once heard a ward-aid say
you know, they don't even wash.
and her disgust made me laugh, though i suppose,
thinking about it now, she had good reason. i mean,
after a hard day's lying in bed one is bound
to get dirty,
and we really should have
washed.

when we were all assembled at the door,
she would count us, to make sure we were
all there,
and inspect us to make sure we were all wearing skirts
SLACKS ARE NOT PERMITTED IN THE DINING HALL
i used to fool her, though, because i wore
a pantdress, and she couldn't really
complain, because who's to say
it wasn't more dress than pants?

we ate in silence mostly, and did not remark on
the guy at the next table who slobbered, it's funny
i remember eating in silence, but still
there was the constant ten-decibel din.
din at dinner, dinner din.

after a suitable length of time our
ward-aid would blow her whistle and call
'Ward Thirteen!'
that was us, everyone got up again, and reassembled,
huddling at the door, while she counted to make sure
we were all there
and we went the long route back again
and through the doors, and back
again
to bed.
you know, they don't even wash!

by Barbara Findlay

MENTAL HOSPITAL

The jingling of keys
inserted into locked doors,
the sounds of lost freedom—
the screaming of profanities
at the staff,
the sounds of insanity;
the clanging of meal trays,
the sound of institutional
food being served,
habitual weeping in the corridor,
the sounds of chronic paranoia:
Suddenly, routine interrupted,
noise reduced to
hushed murmurings:
everyone gawks
at the slashed wrists
and the wet body
of the girl
who was rescued
from a gory death
in the bathtub.
But, now, crisis over
bandages hiding the lacerations
the inner wounds
continue to fester
reflected in
sad, tortured eyes.

by Katherine Tapley

ACQUAINTANCES

*medicine is the main vein
it kills most things
and sometimes the pain
you stroke empty sheets
and dream beautiful lies
I pour your tea
and give you your pills
fold down the covers
and wait for you to die . . . or live.*

by Colleen Wagner

MY WORDS

*my words are
stones are
too heavy to mouth
from me to you they fall
on the ground between us
arrange themselves in layers
become a wall
from which i topple
with alarming regularity*

by Linda King

the silence crests over the distant noise
and crashes around my ears.
wave upon wave
it thunders over me, washing me
into the corner, sucking me back
into its ebb, its beating tide
flooding the room with its relentless roar.

i scramble to find safety in my voice.
my screams fight the silence. i shriek
to throw it back upon itself,
but the coursing, cursing silence crashes on
and flings at me the echoes of my cries
sprayed out hollow in the noiseless spume.

i screech and plead, but my words blow back
foamed to whispers in the mutely heaving sea.

exhausted, i fight no more.
i drown
and the storm is spent.

by Barbara Findlay



aristocrats

(for Diane Arbus)

The camera.
round about her neck.
hangs
like a tribal amulet.
Veiled.
Hypnotic.
It moves to some invisible,
primeval wind.

Click—
Click—

And
She's connected to the infinite;
the Eternal Present— —
Framed and unadorned.

Her soul's a nudist camp.
another dark motel (bound by seedy streets
and sour halls of hospitals).

She's terrified— —
But they keep her alive.
the foresaken. The flesh
of her flesh:
"The Young Man in Curls"
"A Jewish Giant"
"Hermaphrodite at Home"
and
"The Child with Grenade"

Again & again
Calling from the chakra of night— —
A Cuban dwarf in his dirty room:
Stark naked.
Mascarra'd. And
perfumed. (Concealing genitals
between closed thighs.)

Perfect Rage.
Masked, feathered, and crowned.

Captured in their noble madness.
Freaks
She calls
Aristocrats.

by Nira Fleischmann

Sister Woman Sister

Sister
Woman
Sister
Can you still feel any pain
Or have they robbed you of your anger
While putting thorazine in your brain.

Siste

Sister
Woman
Sister
Have the walls grown up so high
That you can't even dream of leaving
And you've forgotten how to fly

Sister
Woman
Sister
Did they take away your child
And lock her up in some juvenile home
To grow up weary and wild

Sister
Woman
Sister
They won't let me come see you no more
But I've still got the poem that you wrote me
It's hanging on my apartment door

The lock on the door won't open
I seek but I can't find you
I ask but you can't hear me

When I'm screaming

Sister
Woman
Sister
You cannot hear me when I'm screaming
You cannot hear me when I'm screaming

Sister
Woman
Sister
Can you still feel any pain
Or have they robbed you of your anger
By putting thorazine in your brain

Holly Near

STILL SANE

Persimmon Blackbridge
and
Sheila Gilhooly
Vancouver, B.C.

These pieces are part of a 25-piece series called "Still Sane" which we have been working on since 1982. Basically Sheila did the words and Persimmon did the sculpture, but we overlapped and worked together a lot. The work documents the three years Sheila spent in mental hospitals for being a lesbian.

We want people to know what it feels like to be drugged, given shock treatments, locked up. We want to show how "crazy" behaviour like slashing our arms can be an attempt to fight back in an oppressive institution.

This series is optimistic even though many of the pieces are quite painful. Sheila DID survive. In a society where we are kept in line by the threat (subtle or blatant) of being locked up, it's important to know that we can resist and survive and win.

Working on this project has helped us to exorcise our past pain and reaffirm our pride as women, lesbians and survivors of the mental illness system. We hope it can touch others in and out of institutions.

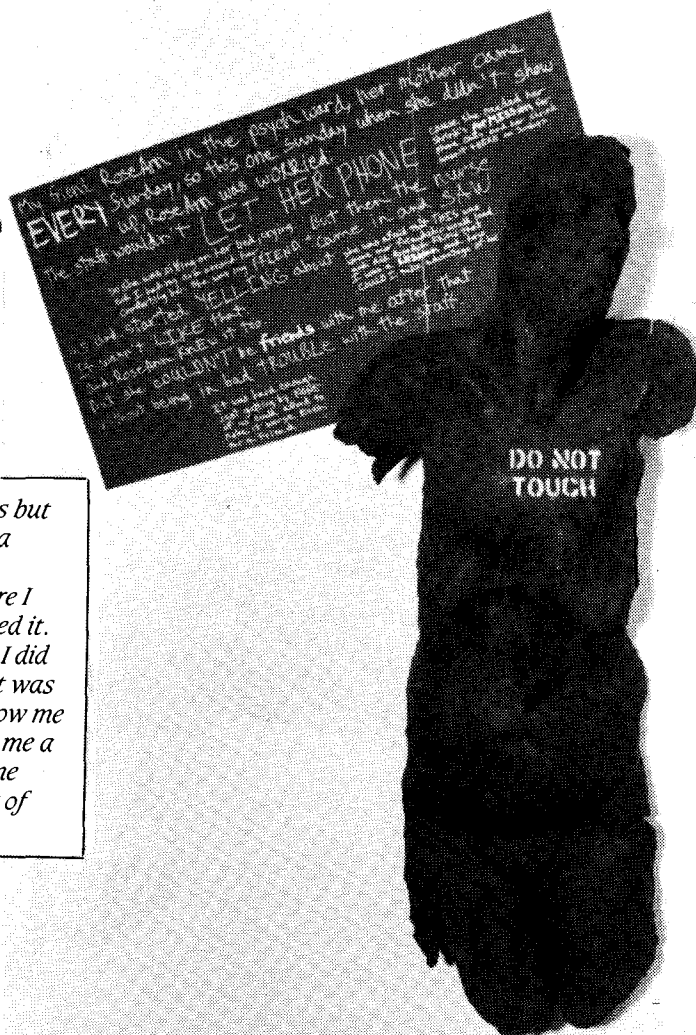
ROYAL HOSPITAL: ROSE ANN

My friend Rose Ann on the psych ward, her mother came every Sunday, so this one Sunday when she didn't show up, Rose Ann was worried. The staff wouldn't let her phone cause she needed her shrink's permission for phone calls and her shrink wasn't there on Sundays. So she was sitting on her bed crying. And I had my arm around her, comforting her. She was my friend. But then the nurse came in and saw us and started yelling about how she was afraid that this was where our friendship would lead and did Rose Ann know that I was a lesbian and how could I take advantage of her. It wasn't like that. And Rose Ann knew it too. But she couldn't be friends with me after that without being in bad trouble with the staff. It was hard enough just getting by. None of us could afford to make it worse. Even for a friend.

THE ROYAL HOSPITAL: DRUGS

Thorazine
Mellaril
Serentil
Stelazine
Haldol
Cogentin
Elavil
Norpramin
Tofranil
Lithium
Librium
Serax
Valium
Miltown
Serenace
Equanil
Tolnate
Surmontil
Nembutal
Fenzol
and others I had to take without even knowing their names.

*Pills sometimes but
more often as a
liquid so they
could make sure I
really swallowed it.
And whenever I did
something that was
bad they'd throw me
down and give me a
shot that put me
out for the rest of
the day*



THE ROYAL HOSPITAL: UNLADYLIKE BEHAVIOUR

On the behaviour mod ward they had this system where they gave us tokens for doing what they wanted, and took them away for being bad. You had to pay tokens for anything you wanted to do, even taking a bath. I remember I had this green plaid skirt and matching sweater I used to get tokens for wearing cause they were trying to change me into their idea of a proper woman. So this one morning I decided to put on my exalted outfit and net a few tokens. I appeared at breakfast all tarted up and this nurse said, "Oh! You look very nice!" in this really phony voice she always used for the patients. Then she told me I'd look better if I shaved my legs. I remember feeling all embarrassed and stupid even though I'd decided long before that shaved legs were silly. After breakfast I signed out the razor and went off to the bath. I think at that point I was planning on to shave my fucking legs.

I remember the rush of blood as I slashed as hard as I could sort of not looking and then looking, seeing the skin all white and puffy like, splitting and then the blood welled up and I sat there and let it run in the bath. After a while someone knocked on the door to use the bath so I got up. I went to the desk and slapped the razor down in front of the nurse with my bloody hand and said, "I'm finished with the razor." She looked at me real angry-like and said, "You'll be sorry for that." They stitched me up without anaesthetic and I remember it hurt like hell but I pretended it didn't.

OUTPATIENT: AFTERSHOCK

After shock treatments my memory was kind of wrecked, even for following conversations or remembering what I had for breakfast. My shrink said it had nothing to do with shock—it was 'cause I didn't want to remember and stuff like that. When I got out of Birchwood it was really hard. At first I was all casual and would say: "Oh how's Aunt Agnes these days?" And it would turn out she'd been dead for six months. It got so no one ever called me cause they thought I was too weird. I didn't even have it together to be pissed off. I just felt scared. I didn't know if I'd ever get better. Mostly everyone thought I was kind of dumb and slow, but really my mind was racing, trying to piece stuff together and avoid pitfalls. The whole point seemed to be to pass for normal, but sometimes I'd wonder what was the good of fooling anyone. Finally I found a job as a shipping clerk at a warehouse. It was simple really, just filling out a few different forms and filing them in different places, but I got confused. Everyone was patient for the first week and smiled and said I'd get the hang of it. But after the second week I got called in to the manager. He couldn't understand why I couldn't do it right. He gave me another week but I did even worse cause I was so frantic trying to remember stuff. So they fired me. After a year my memory gradually improved, though I still have blank spots. A long time later, I found out that memory loss is a common after-effect of shock treatment.



THE ROYAL HOSPITAL: GOING TO STRACKVILLE

Strackville was this big institution, kind of like a warehouse where they stored people they'd given up on. They used to threaten us with it at the Royal Hospital, especially when anyone did get sent there. They'd say, "You don't want to end up like her do you?" and we'd all be scared into submission for a few weeks after. So one day they said I wasn't trying to get better and that when a bed came free in Strackville I was going there. But I had to wait. People would hardly talk to me cause all the staff was telling them: you don't want to end up like her, do you? And of course they didn't, who would?

I waited and planned escapes. I was in a locked ward at the time so there wasn't much coming or going. But one time, I slipped out in the middle of a crisis and made it all the way to a bus depot. But I was pretty drugged up and I must have looked like an escaped lunatic or something cause the cops came and brought me back. I waited for three weeks.

And then the ambulance came. And they put me in. And they strapped me down. And they shut the door. And drove away.

STRACKVILLE: GETTING OUT

I decided I had to get out of Strackville. I decided it didn't matter if I was some kind of crazy person who needed their protection to keep from flipping into some kind of total black-out. I was scared of flipping out but I was more scared of Strackville. Some people spent their lives there. Some people died there. Me, I was going to pass for normal and get out.

So there I was, trying to pass for normal, all drugged up in this place that stinks of shit and lysol and every day is endlessly boring except for occasional flashes of violence and I'm powerless to protect myself and I'm normal. Normal women don't talk about being a lesbian and they're always cheerful. I was always good and smiling, never complaining or bothering the staff, keeping my mouth shut and smiling, always obedient and quiet and nice and smiling, in the middle of this hellhole, smiling and smiling. And I did it. After three months of it I got out.





phoenix pharmacy

A STORY OF VALIUM ADDICTION

By Julie Marks

In January, 1984, I entered a treatment centre in the U.S. to withdraw from Valium, to which I had become addicted. After one month's detoxification, I returned to Ottawa. I was advised by my counsellor to seek a doctor who understood the problem of Valium addiction and, under his/her care, to withdraw slowly, as these drugs store for a time in the body. I had been on Valium for 15 years, so it would take a long time to detoxify completely. The pills were always prescribed by doctors, and I never lied or 'doctor-shopped' to receive them.

On my return to Ottawa, I found a doctor who was informed about Valium withdrawal—he was also very busy! It is hard to find such an aware doctor. As a result, when I was undergoing a severe withdrawal reaction I admitted myself to the Royal Ottawa Hospital. At the R.O.H. I was informed that the program for addiction had a three-month waiting list but, that I could be placed on another ward. I mistakenly assumed that what was known as one ward would also be known on the other.

On the ward, the psychiatrist that I saw was rude and arrogant. He told me that he had never heard of Valium withdrawal lasting so long. I then showed him a book called *Stopping Valium*, and asked him if he would like to listen to a tape by Dr. Fox, the author. He brusquely dismissed both, and went on to tell me his qualifications. He was a pharmacologist/psychiatrist, and believed that all "mental illness" had a genetic base. He said that he would do tests to prove this theory, and then would proceed to find the right pill for whatever diagnosis that he found. I asked him about the kind of support I would get should the tests show that I did not have a genetic illness and that is was, indeed, the Valium that was causing my symptoms. He simply reiterated that Valium addiction would not cause my type of symptoms, in spite of the fact that they are listed as such in Dr. Fox's book.

When I realized that I had been prescribed a phenothiazine and a benzodiazepine—without any tests for "genetic psychosis" having been done—I decided to leave. My psychiatrist had gone off duty, and the nurse called the duty doctor who certified me for five days!

While I was certified, I became aware that a number of the inmates were being used as guinea pigs. Because they were very unhappy when they first arrived, when asked to sign a consent form for a "new drug," they were quite willing to do so (a case of anything that will help?). And, while they were not aware of how drugs were marketed, I had worked as a laboratory technician in research pharmacology and was consequently well aware that "beneficial" effects generally maximized while harmful effects were minimized, calling them "side effects."

When I left university, I—like many others—had not heard of benzodiazepines, and believed my doctor when he told me that Valium was a "mild muscle relaxant". Not surprising, the majority of people addicted to Valium (many of whom are women) mostly are unaware that Valium is now causing them to have "psychiatric symptoms" such as anxiety and depression, hostility, shaking, and nightmares. In fact, four hundred withdrawal symptoms have been recorded by Dr. V. Fox, Medical Director of Peach Tree Hospital in Pomona Valley, California, who has made a special study of the benzodiazepines.

Many doctors and psychiatrists choose to ignore studies which have proven that patients put on Valium for medical reasons only (such as lower back pain, heart disease, and high blood pressure); patients who have not had any previous history of "psychiatric" problems, have also developed the same withdrawal symptoms as those prescribed Valium for their "nerves." If these drugs cause "psychiatric symptoms" in non-psychiatric patients, how much worst it must be for the 'nervous' patients?

Finally, on one poster advertising Valium in large letters that extols its benefits for anxiety and depression (which I saw at the Drug and Alcohol Foundation in Vancouver), there is a notation—in very small letters—that says: "Valium may cause anxiety and depression."

THORAZINE

For Dr. Bob Miller

I'm funny and flat today, yesterday's tea.
These pills have caught up.
(They're doing the job.)
They've stripped the me out of its husk,
they've pounded it down like veal.
However can it re-form now?

I'd rather have giggles and tears,
champagne and razor blades than
This, whatever it is.
I'd rather be deadened by
unmade beds and dust and noise and
blue death in a plastic bag
than be overrun by these
under-the-skin buzzies
without even caring to scratch.

What risk? what disaster averted
makes up for the soul,
ripped out, Comet-cleansed and
replaced sanitized,
without even the taste of the past on
my brain's tongue, its tears, smiles,
And dreads, even?
Not one, good doctor.

Better be found dead in bed
with feeling
that waked prematurely,
sitting in this cold clean room,
my Christian-silly smile pasted on
upside down.

by Bobbie Jean Smith

WARNING!

MENTAL PATIENTS ARE NOTORIOUS

DRUG EVADERS*

Many mental patients "cheek" or hide their tablets and then dispose of them. Unless this practice is stopped, they deprive themselves of opportunities for improvement or remission . . . deceive their doctors into thinking that their drugs have failed . . . and impose a needless drain on their hospital's finances.

When drug evaders jeopardize the effectiveness of your treatment program—

SPECIFY LIQUID CONCENTRATE†

THORAZINE® STELAZINE® COMPAZINE®

brand of chlorpromazine

brand of trifluoperazine

brand of prochlorperazine

Liquid Concentrate is the practical dosage form for any patient who resists the usual forms of oral medication. It can easily be mixed with other liquids or semisolid foods to assure ingestion of the drug.

*According to Goldman, from 25% to 40% of hospitalized mental patients attempt to evade oral medication. (In Trifluoperazine: Clinical and Pharmacological Aspects, Philadelphia, Lea & Febiger, 1958, p. 74.)

†For hospital use



Smith Kline & French Laboratories, Philadelphia
leaders in psychopharmaceutical research

Mental Hospitals, February 1962

Women and Mental Health:

"Charter of Rights Educational Foundation"

Report

Winter 1983

Author: Carla McKague
Contributor: Mary Marshall

Editorial Note: Ms. McKague and Ms. Marshall wrote this article as members of a women's Health Group. The group makes up a portion of the Charter of Rights educational fund to examine gender-based discrimination in government legislation and policies.

Mental Health and Mental Retardation

1. Background

62% of Ontario's psychiatric services are provided to women. Ministry of Health, OHIP Statistical Reporting System, 1980-1981.

Roughly equal numbers of men and women undergo psychiatric hospitalization, but more men enter public psychiatric hospitals and more women enter psychiatric wards of general hospitals (about 60-40 in each case). Elizabeth Bohnen, Women and Health Promotion, strategy paper for the Ontario Regional Office, Health Promotion Directorate.

Women use private psychiatric services substantially more than men.

Phyllis Chesler, "Women and Madness", p.321 (Avon Books, New York, 1972).

50% of people admitted to psychiatric hospitals because of neurosis are depressed women.

Sydney Katz, "10 Common Emotional Problems and How They Affect Women", Chatelaine, October 1983, p.99.

Women outnumber men among depressives better than 2 to 1.

Bohnen

Women also have a much greater incidence of hysteria, phobia, and psychosomatic illness (including anorexia nervosa, which is almost exclusively a women's problem).

Katz, p.99

Women attempt suicide three times as often as men (although men succeed three times as often as women).

Katz, p.252

The highest rate of depression (the most prevalent women's problem) is found among non-working wives with small children at home, and especially working-class women. The incidence decreases with employment, and also with involvement in other activities outside the home.

Bohen

Depression also correlates highly with other chronic problems, including poverty, wife-battering, single parenthood, and the need to both work and carry all household responsibilities.

2. Mental Health Professionals

About 90% of psychiatrists and 70% of clinical psychologists are male.

Chesler, p.64

There is a great increase in the number of female medical students in Ontario, but among doctors in practice there is still an overwhelming imbalance of males.

Naomi Mallovy, Ontario Status of Women Council, "About Face: towards a positive image of women and health", p.5

The typical U.S. psychiatrist (who is, of course, male and in his forties) describes his ideal patient as a young, attractive woman with no more than a B.A.

Chesler, p.64

20% of male psychiatrists in a U.S. study believed erotic contact between therapist and patient could be useful, and 5% admitted to engaging in intercourse with patients. So did 5% of male Ph.D. psychologists. 25% of freshman medical students felt intercourse with a patient could be appropriate.

James Robitscher, p.424-5 "The Powers of Psychiatry" (Houghton Mifflin Company, Boston, 1980)

Sexual contact between therapist and patient virtually always has very harmful effects on the patient.

Chesler, p.152

Both male and female therapists have very different views of what constitutes a normal, healthy male and what constitutes a normal, healthy female. The latter is seen as significantly more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more easily having her feelings hurt, more emotional, more conceited about her appearance, less objective, and disliking math and science. A normal, healthy person (sex unspecified) is seen as identical with a normal, healthy male. Women therefore are torn between conforming to what a person should be and what a woman should be. Therapy may be considered successful when it has managed to get a woman to conform to the female stereotype.

Chesler, p.67

3. Mood-Altering Drugs

These are of several kinds: tranquillizers, antidepressants, stimulants (amphetamines), and sedatives or hypnotics.

U.S. statistics (where comparison is possible, they are in good agreement with Canadian figures) are taken from Robert S. Mendelsohn, "Male Practice" (Contemporary Books, Chicago, 1981)

Mendelsohn

p.60—160,000,000 prescriptions for mood-altering drugs per year, of which only 10% are written by psychiatrists.

p.62—5,000,000,000 tranquillizers consumed

p.61—\$500,000,000 in Valium sales alone per year

p.65—three-quarters of prescriptions for Valium and Librium for conditions for which they are not designed

p.61—50,000 emergency room admissions per year resulting from the use of Valium (either alone or with alcohol).

This is twice as many as for use of heroin or cocaine.

p.61—1,500 emergency room deaths per year from Valium

p.60—women are prescribed 60% of tranquillizers, 71% of antidepressants, 80% of amphetamines

p.60—for same symptoms, women are prescribed twice the quantity of drugs as men

p.60—36,000,000 women are taking tranquillizers, 16,000,000 are taking sedatives, and 12,000,000 are taking amphetamines (mostly as diet pills)

p.61—2,000,000 women are dependent of prescribed drugs

p.61—90% of emergency room Valium visits are by women

Canadian Statistics:

Bohnen—15% of women have taken a tranquillizer in the last two days, and 20% within the last two weeks.

Bohnen—of people receiving more than 10 tranquillizer prescriptions per year, 2/3 are women.

Bohnen—in a study of recovered women alcoholics, 36% were cross-addicted to a drug, usually a prescribed minor tranquillizer.

Bohnen—95% of women admitted to women's hostels are taking tranquillizers or hypnotics.

Bohnen—women take mood-altering drugs in general, and tranquillizers in particular, two to three times as often as men.

Bohnen—the largest single group prescribed tranquillizers is unemployed women over 35.

Mallovy—minor tranquillizers have been linked with birth defects when taken by the mother during the first trimester of pregnancy.

Drug advertisements for these drugs routinely depict women's problems ("empty nest syndrome", menopause, dissatisfaction at home, etc.) as amenable to drug therapy. Ruth Cooperstock and Jessica Hill, "Benzodiazepine Use in Canada" (Health and Welfare Canada, 1982).

Most physicians get a poor grounding in pharmacology from salesmen for the pharmaceutical companies.

Copperstock

4. *Electroconvulsive Therapy*

Electroconvulsive therapy (ECT) is employed on women 2 to 3 times as frequently as on men. Psychiatrists argue that this is because it is most appropriate for depression, which women suffer from much more often than do men.

Statistics Canada, 1975

ECT is a procedure which *always* causes brain damage. It has a number of harmful effects, including memory loss and intellectual impairment, and an estimated death rate of one per 10,000 treatments. Considering that the average ECT patient receives between 5 and 15 treatments, this is a death rate of about one in 1,000 patients.

For numerous references see Don Weitz "Shock Bibliography"

5. *Involuntary Sterilization of the Mentally Retarded*

This occurs much more often with women than with men—probably about 2 to 1.

"Protection of Life Series: Sterilization", Law Reform Commission of Canada, p.42.

There are demonstrated harmful psychological effects on women who undergo this procedure—a feeling of degradation and reduction of status.

Law Reform Commission, p.50

The vast majority of severely retarded people are sterile in any case. Many less severely retarded people are capable, with assistance, of raising their children.

Law Reform Commission, p.41, p.48.

Sterilization of women is frequently done by hysterectomy, in order to remove the problem of dealing with menstruation. This can have very adverse effects on long-term health.

Law Reform Commission, p.34

The drug Depo-Provera may be used as an alternative to sterilization. There is a suspicion that this drug may be carcinogenic.

Phoenix Rising, Vol. 1, No. 4, p. 14

6. *Recommendations*

1. Alleviate root causes of depression and other emotional problems in women through legislative action designed to:

- A) alleviate poverty generally;
- b) provide child care to enable mothers of young children to work or carry on other activities outside the home;
- c) assist women to enter or re-enter the work force;
- d) provide greater support services to battered women;

- e) provide tax breaks for women wishing to employ domestic or child-care help;
- f) fund public education with the goals of
 - i) informing women about how to change their lifestyle to decrease the likelihood of depression; and
 - ii) informing men of their responsibility to share household responsibilities and assist women to have outside interests or employment.
- 2) At the level of the medical school:
 - a) institute affirmative action programs to encourage a greater enrolment of women;
 - b) encourage women to specialize in psychiatry;
 - c) provide much more extensive education in pharmacology;
 - d) educate medical students about the dangers of sex stereotyping of problems;
 - e) educate medical students about the unethical nature of sexual contact between doctor and patient.
- 3) In continuing medical education, provide (and encourage doctors to participate in) frequent refresher and updating courses in pharmacology, ethics, and other relevant areas.
- 4) Through the disciplinary bodies of the medical profession, enact regulations designed to discipline harshly doctors who:
 - a) issue inappropriate prescriptions for mood-altering drugs;
 - b) engage in sexual contact with patients; or
 - c) carry out sterilizations which are not medically indicated.

From "Group" I Learned

From "Group" I learned
under hypnosis, that
memory films of brutality,
(if looked at clearly), can
become a slapstick comedy starring
"Me"

Dressed in a clown costume of
brown face shoved into a closet the
film sped up or played backward or
forward or inside out or
outside in or no side or
yes a side of beef perchance?

Designed (not so cleverly)
to further humiliate and become
entertainment for the over-medicated
listless masses, a
veritable freak show;

This expert from Penetang
made me dance to the merry tune
of abuse.

And this they call a miracle of
modern psychiatry.

by Heather Duff

Therapy, Sexism and Non-Sexist Alternatives

by Bonnie Burstow

Editorial Note: This is an edited version of a taped TV interview between Jackie Yeomans, a staff person with the Women's Counselling Referral and Education Centre in Toronto, and Dr. Bonnie Burstow, a feminist therapist. The interview was broadcast live over McLean-Hunter Cable TV in Toronto on February 15, 1984. The interview was part of a series on Sexism in Therapy and Non-Sexist Alternatives, co-produced by Phoenix Rising and McLean-Hunter. Our thanks to McLean-Hunter for making the tapes available to us.

Bonnie: Our topic today is Sexism, Psychotherapy and Non-Sexist Alternatives, with a primary focus on heterosexual female clients. Four weeks from today, we will be doing a special program on the psychiatric oppression of the lesbian and gay community. My first guest tonight is Jackie Yeomans from Women's Counselling Referral and Education Centre, commonly known as WCREC.

Jackie, could you give us some idea of the original impetus for forming WCREC? What were the problems that people were seeing and what were they trying to do about these problems?

Jackie: WCREC originally got started about ten years ago. There was a group of women in Toronto who worked within the mental health field and other feminists who were really concerned about the kind of mental health resources that were available for women. They were primarily concerned about the number of women who were being prescribed psychotropic drugs by their doctors and then sent home with no other help. Other problems also needed to be addressed. For instance, there needed to be a central referral service for women, one where therapists would be screened to ensure their sensitivity to women and women's issues. So this group of women got together—there were about thirty of them—who looked at what the needs were for a centre, and submitted a funding proposal to Health and Welfare. The doors opened in 1976. We've been going strong ever since.

Bonnie: Where is WCREC and how can people contact you?

Jackie: We're at 348 College Street, between Bathurst and Spadina. And you can reach us at 924-0766.

Bonnie: Originally, when you were considering the question of women and therapy, did you feel that there were special areas related to women's therapy needs that were dealt with more inadequately than were other areas, and so needed your attention?

Jackie: In our questionnaire that we use when we go out to screen a therapist, there are a number of areas that we are looking at. We want to know the therapist's attitudes towards these issues. There are a lot of questions around *power* in the therapist-client relationship, because we believe there is an inherent power imbalance that's set up in that kind of relationship; power based on the professionals being seen as 'experts.' Therefore, the client who is going for help feels that she has less control in the situation. So, what we're looking for is the therapists' awareness that they are in a power position and that they're going to do something within the therapy relationship to break down this power imbalance. Sharing personal information is one way of breaking down this expert-client role. The therapist sees herself or himself as another human being who's struggling with life problems and maybe has learned special skills in order to help the client but is basically . . .

Bonnie: Still human?

Jackie: But is still human. Absolutely. So power issues are big issues that we want to ask about. We also want to know the therapists' views on sexuality and homosexuality, if they feel

comfortable working with gay clients . . . We want to know if the therapist is open and comfortable working with clients who may be living in alternative kinds of situations rather than in stereotyped sex-roles. We want to know their experience with, and their views on ethnicity and class issues as well.

Bonnie: So before you put a therapist on your list as a recommended therapist, you screen them rather carefully.

Jackie: We do. The members of our collective go out to meet with each therapist before they become a part of WCREC, and we spend about an hour with them going through a questionnaire as well as checking out their attitudes on these issues. We're also gathering information on other things that may be of interest to the client. For instance, the client may have preferences in terms of the age of the therapist that they want to work with. They may have a preference as to whether the therapist is a man or a woman. They want to know what type of therapy is practiced.

Bonnie: So besides screening, you're gathering information so that people can shop knowledgeably for a therapist.

Jackie: That's right, because we believe that the client has the right to make choices and in order to do that they need information, and that's WCREC's role.

Bonnie: Just to sensitize our readers to the kinds of questions that are asked of potential therapists, I'd like to read a few. One is: "One of our procedures at the Centre is to give a client the name of two or three alternative therapists. We suggest that she see some or all of them before making a decision. How do you feel about this?" What you are trying to find out through this question is, I believe, whether or not the therapist accepts the consumer approach and a strong client role generally.

Jackie: That's right . . . When we're considering a therapist, we want the therapist to believe in that approach, and that attitude should go right through the therapy—that it's a partnership, that the goals are determined largely by the client. The goals, the process, the termination should be handled as a partnership.

Bonnie: So you're after a contractual arrangement that respects the integrity of the female client.

Jackie: That's right.

Bonnie: There are some other questions in the questionnaire that I would like to ask about, partly to find out what you would consider an acceptable answer. Here's one: "At what point would you refer for: a. tranquilizers? b. committal? c. shock therapy?" What answers would be beyond the pale?

Jackie: Well, those that say, "I recommend lobotomy weekly" are out definitely. Because therapists have different views, we don't have a hard line. There are some therapists who won't prescribe any drugs and won't see clients who are on drugs. However, there are some that say while they don't like using drugs, they may prescribe tranquilizers for a week to help them through a crisis situation. We want to know . . . that they're dealing with the issues, not just covering them with the tranquilizers. As for committal, most of our therapists will just say that the law is very clear and they follow the law on that. Most of our therapists are not psychiatrists, so they don't have much say in that area anyway.

Bonnie: But they can encourage or discourage, and they can influence, so their opinions on the matter may well have some kind of impact on their client's future. WCREC's position here is important.

Jackie: . . . Our basic feeling is that there's not much to be gained from incarcerating somebody against their will.

Bonnie: Okay, that's what I was checking. What about the third area—electroshock? If a therapist feels that shock is a reasonable treatment, would she be acceptable to you?

Jackie: We have real difficulties with shock therapy. If there was a therapist we were interviewing who said that he or she wasn't sure about it and was really wonderful in all other areas, we wouldn't send a client there who might be deeply distressed.

Bonnie: So you'd be careful about sending them anyone you saw as in high risk of being referred for electroshock? I think I

understand . . . To go back to the consumer approach. How have people been reacting to it?

Jackie: We put it to people as an option. People who come to our service are told that they have the right to "shop" and that we recommend that they do so. It's often difficult for a client, particularly if she's going through a period of stress, to think about the idea of going out and interviewing two or three therapists. To go through the whole story several times is a very painful process. However, other women who aren't in that kind of emotional turmoil are delighted to know that such an option is available to them; they go off and shop, and they're very happy with the results.

Bonnie: I imagine they find it an empowering experience.

Jackie: That's right. It's taking control of your own therapy. . .

Bonnie: Are there many psychiatrists on your list? Now, I know that they can't be in the *Handbook per se* because psychiatrists are not allowed to advertise, but do you have a private list?

Jackie: We do have a private listing of psychiatrists and also medical doctors who do supportive counselling, but they don't make up the largest percentage of our therapists. We have psychiatrists, psychologists, social workers, people who have a background in counselling, and lay therapists who don't particularly have an academic background but are well-trained in a certain type of therapy. We don't feel that the academic background is the most important thing. The most important thing is that a person should be looking for someone that they *connect with*, someone that they're going to be able to trust and open up to. They need to find someone who specializes in the area that they want to work on, and they need to find someone who practices the type of therapy that they're going to be comfortable with.

Bonnie: I see no difficulties for those clients who aren't forced to rely upon OHIP (Ontario Health Insurance Plan). What is likely to happen to a working-class client trying to raise a family of 7 when this person is looking for a therapist?

Jackie: It's much more difficult. It's a very unjust system. As you say, a woman who can afford therapy has all kinds of options available. For the person who can't afford to pay over OHIP . . . the same options are not going to be there. Often, they will run into waiting lists, because the therapists on our files who are covered by OHIP or the people within agencies that charge on a sliding scale tend to get booked up very quickly.

Bonnie: One of the alternatives for people with little money is the self-help option. I understand that you've recently come out with a self-help *Handbook*. Would you like to tell us about that?

Jackie: I'm glad you asked. We are very strong supporters of self-help at WCREC, because we believe that a lot of people get channeled into therapy that they may not need. Maybe what they need is just to connect with other people who have the same kinds of concerns and interests. They need to get together with other people for validation and support. There are self-help groups where women can come together to do just that, and we try to facilitate groups through WCREC as often as we can. You can call WCREC if you're interested in getting together with other women for support, and we'll get you on the list.

We've also put out a handbook called *Helping Ourselves*. It's basically a "how-to" kit for women who would like to start a self-help group. It's available at WCREC for \$5. You can give us a call or write to WCREC and we'll get you a copy.

Bonnie: I think you do fantastic work. I see you as a very valuable asset to the Toronto community. At the same time, I'm painfully aware that some of what you're recommending, while very viable for people on this side of the "mental hospital" wall, may not be of much help for inmates. Psychiatric inmates don't have the types of choices you're talking about. They can't shop around for a therapist, and generally can't form support groups while inside hospitals. Do you have any

suggestions for people inside institutions who are being dealt with in a sexist manner, insensitively?

Jackie: I think that's a question for ON OUR OWN, because ON OUR OWN is dealing with this problem all the time.

Bonnie: You're quite right. Do you have any resources that institutionalized people can use to help them exercise those choices they *do* have? To give you an example, one thing an institutionalized person can do is get a decent lawyer to represent her at review (board) hearings. Do you offer help in this area?

Jackie: Yes. One of our resources is a list of lawyers. We haven't gone out and screened them in the same way as we've done with our therapists, but there are lawyers in our files that have been recommended to us as being particularly sensitive to issues that affect women and who have a humanist philosophy.

Bonnie: I'm glad to hear that. I don't think most women are aware that you have such a list.

Bonnie: To go back to the more central issue of therapist "shopping," I understand that WCREC has a clients' response form. Women get a chance to tell you whether or not they've gone to see a particular therapist, whether the therapist has or hasn't been of help to them, and so forth. Do many women fill these forms out?

Jackie: Yes . . . The first follow-up is to find out how they have made out while "shopping" for a therapist; whether they've acted on the suggestions that we've made. To get further feedback on our service, we call the client again, about three months later, to find out how she is making out with the therapist.

Bonnie: So you initiate a second follow-up?

Jackie: Yes, we do.

Bonnie: Have you ever removed a therapist from your referral list on the basis of the feedback that you've received?

Jackie: When a client calls and says something wonderful about a therapist, we make a note in that therapist's file. And, if they say that they're unhappy with a therapist under a certain situation, we also record that in the file.

Bonnie: On the basis of negative feedback, have you ever removed a therapist from your referral file?

Jackie: Yes, in extreme situations and after discussion with the client and the therapist.

Bonnie: One thing that I suspect some people don't know is that the WCREC *Handbook* contains the names of non-sexist male therapists. Sometimes women want to have non-sexist therapy with male therapists and, though they may be few, they *do* exist.

Jackie: About 10% of the therapists in our file are men. And you're right—some women want to work with a male therapist. One client who was working on feelings of anger toward men felt that she wanted to work that through with a male therapist, and since that was her choice, we sent her to one.

Bonnie: That makes sense. In wrapping up, if you could give only one piece of advice to a woman who was looking for a therapist and who was concerned with being handled in a sensitive, non-sexist manner, what would that advice be?

Jackie: Again, it comes back to the issue of *power*. I want to let people know that they do have some power within their lives . . . and that they have the right to make choices. First of all, decide what it is that you want, then go out and make sure you get that for yourself. And, if you're dissatisfied, go somewhere else.

Bonnie: What would I recommend to women in this situation? I would like to recommend that you interview therapists not only generally—about their therapeutic beliefs—but that you also interview them about themselves. A therapist who has never been through therapy herself may well have all sorts of skills but at the same time, be quite insensitive to what you're going through. With some problems, it is much to your advantage to find a therapist who, if possible, has a similar background. It's only one thing to consider.

Jackie, I'd like to thank you for being here tonight.

Jackie: My pleasure.



personal stories

JOURNAL

By Nira Fleischmann

NOTE: The following journal was written while disintegrating for three months (May-July, 1983) on the psychiatric ward of the Ottawa General Hospital.

May 18

Afraid of being here. Afraid of Being—of losing myself, of falling backward, of empty space, of FEAR.

Psychiatrists, priests of science, play with their puppets, their vials, their tangled wires, and me—performing for free . . .

Paralysis of mind & voice. Everywhere masks, walls, doors that can't be opened, and inmates rocking to slow, violent rhythms—as earthquakes shatter minds into rubble; rubble into dust . . .

Bitter laughter and blame. Traps. And voices begging for sound. This nightmare dances round us like some crazed whirling dervish—donning a white coat, cutting circular incisions, and LOCKING THE DOOR!

May 20

'Group Therapy'—locked inside again, a circle filled with the sound of God's laughter.

Sorrow, too, imprisons us. One private hell winds itself around another & another & . . . pain pervades this space with an intensity so overwhelming that I can barely breathe. Even the cracks in the walls seem to cringe.

Denied even the simplest comfort—a language that could communicate the grotesque horror of our being here. Everyday alphabets talk of cold reason, boundaries, lines, definitions—senseless to God's fools, knowing themselves at the mercy of wanton boys . . .

Left with labels only. Tattoos drilled in acid across severed arms, severed heads, into our planets and across our severed stars.

It's a deadly cliff here. Fractured bodies holding each other. Some try to grab hold of 'doctor' . . . but the hour is up.

May 24

How to transcribe the heart on to the page? To cry in words? Impossible—when it hurts too damn much even to feel.

The horror is to have fought so hard—to have reached up and actually touched the tip of the cliff—and then, suddenly to feel the fall backwards, and the scream, endless & unheard . . .

Desperate to write again, but the rhythms, the harmonies, the echoes—everything is lost in a fog of feelings without words.

10:50 p.m.

There's a teenaged girl sitting across from me in the 'day-room'. Recalls myself, ten years ago . . . ABANDONED. Written with such calculated coldness, calmness. Couldn't be borne any other way. Shaking inside, I'm unsettled suddenly, and wanting to hold her . . . Perhaps it's the endless mirror that lends any sense to these doors that never slam; that lock with a whisper and a memory that I'll shudder from until death. Can't find words for the girl either.

Only light, the flashing shadows of the T.V. screen. I sit fighting the torment and trying to mediate between pen & hand; brain & page; mind & guts—between past, present & future.

May 25

Too much of everything. Am like a rain-barrel, utterly drained.

Do any of us really survive? Perhaps to end up in back-alleys, feeding dingy old stray cats?

May 26

I carry this notebook with me everywhere. It's as if it were some slow kind of torture . . .

Between these pages is a wild sea raging uncontrollably. Its enormous waves engulfing me in tortured silence that *NO* language can describe. And you never stop asking us—demanding us—to *feel*, 'to tell us all' . . . but refusing to acknowledge the claustrophobic panic of being left, bound and gagged in some corner of hell . . .

The Occupational Therapist, smiling, dragged me away to a 'group-humiliation session'. We grab our coloured markers and our brown, meat-wrapping paper! She collects all of her contempt; pins it up on the wall; and sweetly vomits abuse all

over us—in tones of kindergarten kindness . . . that echo '*Ach Dung!*'

The shrinks, the nurses, and all the other goddam CARETAKERS scare the hell out of me, with the autocratic attitudes and patronizing approach, not only to 'the Kept', but to the whole y bloody world!

LOCKED IN. LOCKED UP.

Terrified of the hellish drugs that creep into my heart, my mind, my soul like a poisonous snake, constricting itself around me tighter & tighter until I've no strength left to struggle.

May 29

Thought about Mme. Fontin all weekend. Her face will always haunt me; her screams, echo forever. . . . Shades of 'Miss Coral' . . . a woman frail as a shell, gentle as a whisper, transformed by primitive violence into a cinematic madwoman. The night before her treatment she complained of a blinding 'headache'. Of course, she was ignored. Then the middle of the night screeching, kicking, & throwing her own shit all over the nurses, trying to grab her with leather belts roped around their arms. But she wouldn't let them even get near her. Running up and down the hallway and into my room, she bent over my bed, trying to persuade me that we both had to get away; that killers were after us. She yelled in a broken French that I barely understood, except that, pursued by hellish apparitions, her butchered memories suddenly reappeared at 4 a.m.—as the *visage* of a butcher, waiting with a bloody knife.

May 30

Must try not to listen, always, so closely; too closely. Fear of interrupting; of complicating matters. Somehow, must find it within myself to speak again, to escape my silence.

Undeserving. Of breath itself.

June 5

How to placate *my* 'dark angels'? They claw & batter my insides, unendingly.

How to react to someone who *did* cry out—who daily pleaded and screamed—and *died* for all the good it did her? What the Hell do we feel? There is numbness, and it aches & aches. She was a 'bother' to the nurses, crying out with the terrible pain she felt in her belly.

She's dead. Hung herself. In our bathroom hanging from the time of her hospital gown. Head fallen over the shower rod. Dead. Wax-yellow, spittle down her chin. Dead. Love of God leaves a bitter, bitter taste. And numbness that cuts through me—razor-raw, bloodless. Ineffable.

My head aches with the enormity of it . . .

Horrific images press down on me with a heaviness that I can't escape. When I look outside at the trees, I see her desperation. I imagine her, moments before. The strength of her pain was gigantic. It lay on her back like lead. It made her an icon of our collective Hell. I couldn't bear to look at her; often I was angry. It came from looking too deeply into her gashed insides. I wanted that pain to stop; at least to become veiled under . . . the words are futile in the face of this horror. I can't stand to write or to stop writing. She wore a bright orange housecoat. She was small & dark & her face was wrinkled by the oppressiveness of nightmare indescribable. She cried always, like a small child. The cry of drowned innocence. It hurt to hear it. Maybe that's why they never listened . . .

June 7

André spoke in 'group', a triumph of sorts. Celebration and devastation are called up at once here. The occasion loses significance; fades into dim shades of grey. It's a garish collage, this insular universe, where inside is outside and death, the gift of spiteful gods.

Dinner 'is called'. I hope someone takes Frank and helps him to eat, else he'll surely starve to death. Is the responsibility too awesome?

No matter how much they try to impose regimentation upon the 'blood-dimmed tide' they fail.

The 'ceremony of innocence', once drowned, can't be revived.

I'll surely disintegrate, unable to write and reading just barely. Damn—the waves are heavy and the current is strong. They drown without thought to their victim. I breathe now only with great labour. **TERROR FLOATING THROUGH AIR . . .** Sometimes feel as if I'll never surface, yet know I'll never drown.

June 15

Recollection of joy . . . discovering that I could read. The library was the world caught in a mirror—my *own* world—because the words whispered their secrets to me and I heard their music. And because I was enchanted. Now it's as if the world's been stolen. Radically along again, I feel detached from outside & inside: utter fragmentation.

June 20

Insights reached through years of solitude & introspection have such a fragile foundation, if any at all. Maybe we're all Jonah's and out of nowhere can be swallowed up in a darkness only God can conjure . . . so much is hidden.

'Group' . . . Not again. My studied composure falls limply on otherwise unnoticed linoleum tiles.

June 21

Five weeks in hospital. Overwhelmed.

Books I have with me now are alive not with grace but with menace. The love affair is over in a bog of threat & recrimination. Shadows of dullness splash hideous darkness all around—irrational, impossible to confront, and growing in magnificently distorted proportion. Still, despite all failure, am denied even the peace of giving in.

June 26

How to distinguish darkness from the soul? Too vast for understanding. Layer upon layer refracting darkness without end or beginning. Can't find even the most arbitrary boundaries.

Would sacrifice everything for the chance to work, to write, to create, to soar. Without this freedom, Self erodes.

Soon everything turns to dust & ash.

"Group": sounds of despair. The constant cries tear through me. I think I'll dissolve. To hold myself together, I wrap my arms around me with all the sheer strength that I can gather. Wandering about our fog, a crazed magician. Conjuring anger & pain from the dead center of the room, he permeates this circle like poisonous gas. Always, there is the sensation of choking suffocation; of distance creeping inward, of being slowly strangled to death. Perfect anguish: fingers tightening about the heart.

June 29

In the mirror I see a sewer rat scrambling about in the dark and banging constantly against the walls that block each possible passage to escape. But the rats are survivors. They fend for themselves almost from birth. Scurrying rodents that see in the dark.

Is there a face to this notebook? There is a core—Memory—but everything outside of it is lost, eroded, or never was. Must hold on very tightly . . .

July 7

Can't describe the terror that's splashed across these walls. It's a private legacy . . .

July 10

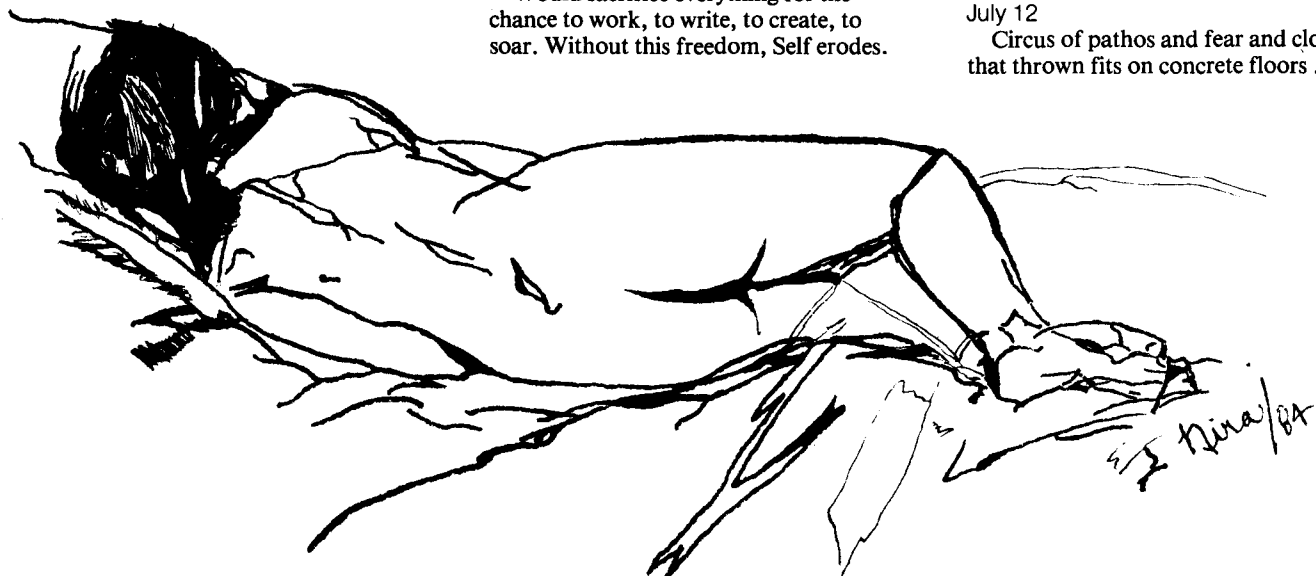
Cannot write about the pain, so enormous, etched into the heart; engraved on every face. Cannot write about how we somehow each set aside our private hell & find the last bit of strength to soothe each other, to take hold; to share the collective nightmare. Cannot write about the shrieks, the voices; about all of the tormenting angels. Cannot write about perfect anguish.

July 10

All threads hopelessly severed . . . Our aloneness is complete. God must surely be some kind of blind maniac! Does He see us—any of us at all—here, in this obscenity? This God that ravishes with phantom voices, and with bloodied fist, He is Violence and sanctified Despair.

July 12

Circus of pathos and fear and clowns that thrown fits on concrete floors . . .



July 13

Voices inside, the inescapable 'I' . . . & the heart, too, is never still. Silence crashes her fists against the walls. She thrashes & bangs while the darkness screams desperation. Steel bars seem to multiply. The cage collapses inward. It feels as if there's nothing that doesn't hurt. Even the room, the dark, it all hurts.

July 15

Happy birthday. Celebrate myself? The thought alone is grotesque. There is only dread, wrapped in a box of loss & tied with poison ribbons, pink & lethal . . .

July 17

The nightmare—reality. Simple. No puzzle after all. Because *nothing ever fits*. Just billions of pieces of different colours and contours, and in the end, just different landscapes of disintegration.

There's really *nothing* to hold on to. All the reaching upward has been a mockery. And it's a *malicious* laughter after all is said and done.

I passed Suzanne's room as guards, nurses, and doctors are forcing a tube down her throat, deeper & deeper, until it will reach her stomach and they'll feed her—for her own good . . . Salvation in a plastic bag, a tube, a hideous turquoise solution. She doesn't utter a sound. And a certain grace surrounds her there, on that bed where they've caught her, captive of leather belts & tangled bedsheets. She doesn't scream. She doesn't try to fight them. There is no fear, and I walk away strengthened. Ankles and arms pinned down, she's stripped their almighty power with a defiant peace. And eyes that see beyond the hellish geography of these rooms and walls . . .

July 18

Noticed something about this scribbling—its face is just another fragment of just another phantom . . .

Can't even borrow peace.

The Growth of a New Self-Help Group

By Wendy L. Decker

Last April I was fired from an agency, Rehabilitation Support Services, (in Albany, N.Y.) for "violating professional ethics" and "overstepping professional boundaries." I had worked as a group facilitator, creating a poetry/creative writing group, a world issues group, and a collectively published newspaper as a vehicle for our writing.

A friend involved in our groups found himself in a crisis, and was living on the streets with no food or money for two weeks. When he told me of his situation, I invited him to rest in my home over the weekend to clear his head. As stated, this was a person that I knew well—my friend, and my first violation as a "staffperson" overstepping "professional boundaries."

I was immediately suspended when this information found its way into the professional hierarchy. And, four days later I was fired for these reasons, as well as my "attitude" toward authority. I questioned (another offense) the right of the agency to tell me who I could invite into my home, only to be told: "as long as they're *our* clients, we do have a say in who goes to your home, and you're projecting a very confusing *ROLE* to *OUR* already confused clients, which makes you dangerous to *OUR* clients." I then questioned their "ownership" of the "clients" mind, body, and soul.

I also challenged their "professional" ethics which did not take into account our personal, human responsibility to each other. Direct action at a personal level is in complete contradiction with the "professional" psyche, which states we must be "trained" and "certified" to meet particular (segregated) "needs". Within this conceptualization I was doing a "disservice" to my friend. It was clear we were talking very different ethics. Empathy, compassion, friendship, had no place in this professionalized world, and

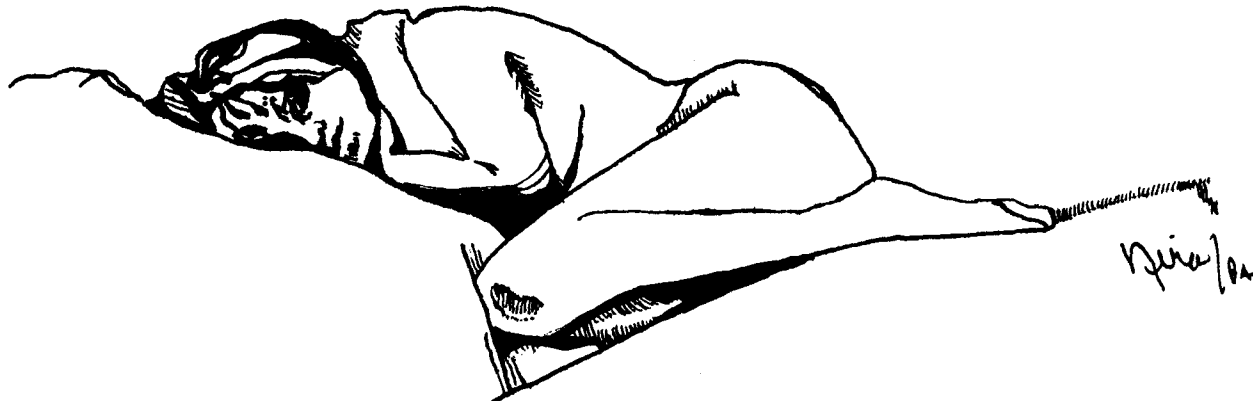
what I refer to as "suicide ethics" penetrates the consciousness of its workers. The "person" well hidden behind their "title" is severed from the very basis from which human experience fosters growth and a sense of self-worth, through the act of sharing, *as equals*, ourSELVES.

It is now eight months later. My friend still has no stable housing. In the interim, he has been on the streets, in de-tox, re-hospitalized, discharged, back into the streets, and finally into a dilapidated boarding home, while the various holding stations count their \$\$\$ from the State.

I've told you my story in order to provide a better understanding of what this worker encountered, trying to transcend the barriers which reinforce the "structural oppression" found in most of our social institutions today; which, by the way, newly trained social workers are not "taught" to address since individual pathology has become the universal scapegoat. Since my "termination," ten people (who once attended the groups I facilitated) and I formed an autonomous group called "On Our Own" to be a support group, independent of the "Mental Health" Industry. Originally our stated purpose was to provide personal support in our daily struggles, through listening and sharing our experiences and, secondly, to inspire each other to develop writing as a tool for self-expression.

Our long-range project was to publish our work in a journal; to provide a vehicle for our voices to be heard. We were organized as a collective and decision-making was to be based on consensus (as were the groups I facilitated for RSS). In the beginning, there was much energy. My friends wrote angry letters to the executive director of the agency, circulating petitions, and thrust themselves into planning our newly-found group. The feelings of solidarity were overwhelming.

Problems, however, inevitably arose. The different reasons for people being present came to the surface, as I realized many of my friends were there for me, rather than for themselves. Unlearning the passive existence of consumption was another problem, as many people had spent a number of years in institutions, and self-empowerment was an abstrac-

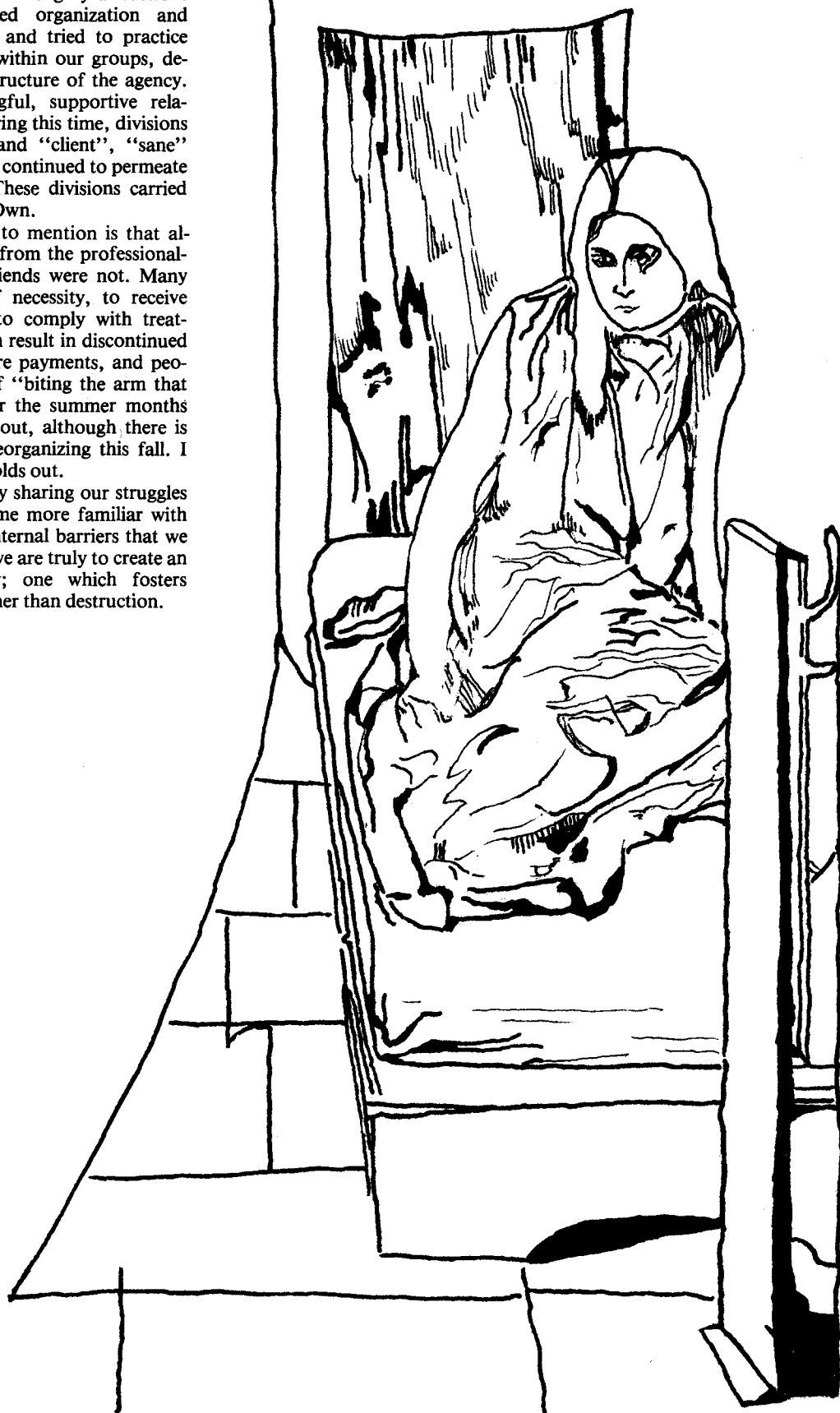


tion. Most people waited for a leader to come forth, and I having been "trained" for eight years, rose to fill the organizational gap until my consciousness caught up with me.

In the past we had lengthy discussions about decentralized organization and equalizing power, and tried to practice these alternatives within our groups, despite the overall structure of the agency. Although meaningful, supportive relationships arose during this time, divisions between "staff" and "client", "sane" and "competent", continued to permeate or relationships. These divisions carried over into On Our Own.

A major point to mention is that although I was free from the professionalized world, my friends were not. Many continued, out of necessity, to receive services. Refusal to comply with treatment, after all, can result in discontinued disability or welfare payments, and people were fearful of "biting the arm that feeds them." Over the summer months our group fizzled out, although there is some interest in reorganizing this fall. I hope our energy holds out.

I thought that by sharing our struggles we could all become more familiar with the external and internal barriers that we must overcome if we are truly to create an alternative society; one which fosters human growth rather than destruction.



Lessons In Powerlessness

One basic misconception of psychiatry is that this society is good and there is something wrong with the individual. Most psychiatrists believe that patients' problems stem from a failure to adjust to social standards, or to 'find one's niche!' Living problems therefore are attributed to the patient, and she or he is seen as the one who must change. Even "progressive" psychiatrists, who will admit that society is sick, often still see the individual as powerless to change it. Most people in the psychiatric profession show horror, and start writing very busily, if one expresses any desire to change society. It is considered, at best, a phenomenon of misguided youth and, at worst, a delusion of grandeur.

Psychiatrists often use their power to further instill societal values. In this way, they become agents for the establishment. A popular assumption is that anyone with psychiatric problems does not know the rules well enough, and must be taught, by whatever means, to behave differently; that is, in accordance with established societal values. That the rules are wrong is never considered. Not uncommonly, the 'patients' are encouraged to talk about their experiences, and the psychiatrist teaches them how they were "wrong"; how to handle things differently in future.

that their own belief system is being replaced by another one. They rarely get a chance to argue or defend their behaviour. The other, "sane" person is always right.

While therapy could, and I think should, be at the forefront of social change, the problem is that within the psychiatric establishment, people are seldom helped to see the oppression against which they are fighting, and will not be surprised if they do see it. A sensitive therapist, however, committed to acknowledging the validity of the patient's viewpoint, could support changes in behaviour which are not currently socially acceptable, but rather are exploratory and pioneering. This method requires political analysis, creativity, and caring-qualities in which psychiatrists, as a group, are lacking. In fact, usually there approach is the opposite: to re-teach societal values.

When I use the term "political", I am referring to theory and actions within the context of the feminist movement. To change the way a large portion of the population behaves is a political action. Feminist political action ranges from refusing to wash his socks to bombing por-

nography outlets. I do not agree with every political action but I do believe that psychiatrists, as upholders of the status quo, have inhibited much social change.

Psychiatric difficulties usually occur as a stage in a person's attempt to make a change in her life. What people need is support and help to go *through* the changes and to emerge victoriously on the other side. Psychiatrists, for the most part, avoid addressing this need, and it is for this reason that I want to explode the myth that the psychiatric establishment is helpful in any positive, constructive way.

A prevailing myth in psychiatry is that drugs can "cure" you. Many psychiatrists see 'mental illness' as a biochemical or genetic problem—a theory which once again takes the heat off political realities and places it on the individual. The expectation is that chemicals can cure you as if you had some kind of bacterial infection. I've been told, for example, that the reason I was angry at seeing hundreds of kids regularly beaten and abused—when I was a child care counsellor—was because I lacked lithium in my blood stream. And, that my anger at my father for molesting me was the result of a delusion that could be "cured" by anti-psychotic drugs. They sincerely believed that once the "delusion" was "cleared up" by the drugs, I would cease to feel angry, because I would have nothing to feel angry about.

Drugs, in fact, do little but make you insensitive to your feelings, and too drowsy to act. Anger, sadness, and fear all are emotions that we have to feel in order to work through traumas, past or present, without an outlet for the emotions. However, while drugged, you become cut off from your feelings. Helpless to find answers for yourself, you therefore are very susceptible to influence from psychiatric personnel, who want to be in charge of providing the answers, because it is their answers that reinforce the status quo. Furthermore, while at S_____, I became very afraid that both the kind and the dosage of drugs would cause a disorder known as tardive dyskinesia, an irreversible and often fatal condition. My doctor refused to change the medication, saying that my "illness" was worse than any side-effect.

Without feeling your feelings, it is often hard to get in touch with what is bothering you, let alone decide on a plan of action. Thus, again, drugs take the solution to the problem out of your hands and leave you vulnerable, depending on other people to tell you what is wrong, and what to do about it. A woman I once knew in hospital had been severely depressed and had been getting shock treatments. One day she started to get angry. Instead of supporting her to finally get out her rage, the nurses apologized for "putting too much stress on her," and heavily medicated her. Though it is now known that depression is a re-

sult of repressed rage, the message clearly was that it's not okay to be angry: You can talk about angry feelings but it must be in a nice, quiet voice.

Finally, there is the classic double bind. If you go off the drugs so that you can start dealing with your problems, and then experience any difficulties, they say that the problem is that you went off the drugs.

People who sign themselves in have internalized their oppression, and are victims of the lie that the hospital will help them to make sense of it. Hospital life, which is supposed to be intensive therapy, helps no one to make sense of anything. The inculcation of traditional values operates on every level. There is a rigid routine, based on "early to bed, early to rise", "idle hands are the devil's workshop", and "do something to take your mind off it." Most of the time spent in hospitals is either unproductive sitting around, or busy work. It's hard to think when you're heavily drugged, and in the hospital, there's no possible way to act on decision. You can think forever if you want to, but any conclusions you come to, in terms of action, are thwarted. You're a prisoner.

Busy work (making collages, folk dancing, bingo, etc.) inhibits even the process of thinking, and is often used against you as well. At S_____, activities were presented as something to "just have fun doing", and then the results of art work, etc. were periodically confiscated "to show your doctor". What the doctor thinks about what you have done is never revealed to you: most information is put towards forming a diagnosis, not towards helping you get to the roots of your problem. The assumption here is that the doctor can solve it and you can't.

The medical model encourages the use of drugs, labels, and authoritarianism. The process of overcoming distress is taken out of the hands of the patient, and put into the hands of the psychiatric staff. You lose all rights in the hospital. I think that Ontario's *Mental Health Act* itself is a violation of human rights: you can be committed on only the opinion of two psychiatrists, and have no rights to defend yourself. This means, essentially, that you are guilty until proven innocent. You have no right to choose a therapist, no right to choose the type of therapy, and no right to change therapists if you are unhappy with the one you've got. Decisions and choices are taken away from you, often right down to how many cigarettes you smoke, and how many phone calls you make. Visitors can be restricted, and in and out "privileges" are firmly controlled. Everything is done in the name of therapy, which means that it's harder to argue against effectively. Essentially, what they are doing is teaching you to cope with a lack of power, and a distrust of your own decision-making ability. This is the lesson

they undoubtedly think will serve you well in the outside world; a little more subversive, a little more attention to orders, a little more resignation in the face of not getting what you want. Tolerance

Drugs, physical force, and a loss of basic rights are used to elicit total control in terms of following the rules. One woman reports that two male nurses forcibly removed her from an off-limits place, and then drugged her. The message is that if you disobey orders, you're sick and need medication. Their reaction to disobedience usually takes a more subtle form: so long as you "refuse to co-operate", you obviously "need more treatment" and your discharge is delayed. Or your passes are revoked because you're "too upset to be going out in the community."

From psychiatric nurses and psychiatrists, all you get is a re-teaching of the traditional values of this culture in a new language. Sexism is rampant. I was told that I was "schizophrenic" because I had a "delusion" that my father molested me. I was also told not to talk about it, because "it only increased my anxiety". The fantasy that it was a delusion was based on an interview with my *father*, a breech of confidentiality, and an example of how psychiatry upholds patriarchy. Another woman reports that she was told not to talk about a recent rape, because "it would upset the whole ward." The problem of sexual assault by her father was never even discussed: obviously not part of the problem.

Another woman I met at S_____, who had been beaten daily by her husband, finally got enough courage to go away to a big city nearby. She ended up in the hospital. The husband talked to her psychiatrist, who told her that she had to take him back and give him another chance because he, the husband, was "sorry." The psychiatrist reinforced his views by kicking her out of the hospital. She had no money, no friends in that city and no knowledge of resources. She went back to her husband for survival.

More sexism. A friend reports the disgust and curiosity of a psychiatrist upon hearing that she was a lesbian. His response was, "Do you have *full* sex with her?" The implication is that sex between women is not believable and, I think, is based on the negation of women's sexuality in general. Women only "respond to men". This psychiatrist also suggested that my friend find a man instead because, he thought, a man would support her financially while a woman would not. The negation of the emotional importance of the relationship is typical.

It is my experience that psychiatrists rarely deal with real issues and, instead, try to decide for themselves what the problem is. You lose control of your own distress. A good example is my experience

of being molested by my father. The series of incidents surrounding that were totally avoided, and other parts of my personality and lifestyle were attacked. When I was going through the pain of separation from my husband, I was told that I was experiencing the pain of "not knowing who I was". As well as not helping to deal with the actual feelings, this treatment convinces you that there is something wrong with your perceptions. It makes you dependent on others for something wrong with your perceptions. It makes you dependent on others for answers, because they obviously see things that you don't. It enlarges the problem by making you feel even more helpless. There is no end in sight: therapy will take years while they reconstruct you to a model of their liking.

There is a process of debilitation that takes place as your psychiatric record grows. I think it is a deliberate attempt to reduce people who refuse to learn the lessons well to outcast status. The first time you go to a psychiatrist, you are treated as a person with problems; the second time, you're hospitalized; and the third time, you're diagnosed. There is a whole psychiatric underground that most people don't know about. This consists of daycare and psychiatric boarding homes, the repositories for people who are "beyond hope." As both hospitalization and daycare interfere effectively with work or school, people often lose their jobs, or have to drop out of school. This makes life that much more difficult when they get out of "care". Deliberate or not, this process reduces the contact that psychiatric inmates have with so-called normal people to nil and ghettoizes them. The lesson is: "If you don't follow society's rules, we'll strip you of what little power you do have."

Lessons in powerlessness are taught by people who are very good at their jobs. As a group, psychiatrists are among the highest status members of society. Most of them are probably good people who, seeing easily for themselves how this system works, want to help others by passing it on. However, just because they *are* at the top, they have a vested interest in maintaining the status quo. Any attempt to redistribute power in this society, which is what political work is all about, is definitely taboo.

I believe that feminist political work includes keeping people out of the hands of psychiatrists. If the movement is to become universal it must include those people on the fringes, who have not been able to make a feminist breakthrough on their own. Similarly, there are many men and women who unconsciously support a left-wing, anti-capitalist stance, but who have been too troubled to see that their problems are not personal but political. The men and women who cannot cope

with the world as it is could readily be enlisted in the battle for change, if some time were spent with them, dealing with some of their own specific problems. And political action could be their salvation. Lessons in power.

By Jillian

Centenary 5 Hotel Dieu

by Bobbie Jean Smith

The sun streaks through the room.
I shiver back its rays.
(There's no igniting this hibernal core.)
No-lock doors—bedroom, bath or loo,

No place to hide, but
Hide I do
Beneath my raggy quilt from home,
(The cosy smell of soured milk)

Behind this smile
And glacial eyes performing tricks:
Good morning, lovely day, oh yes I'd love
To make a moccasin or two.

And just how sane today are you?
One half-hour sane is all, a
Hurried trip to library
Sprinting on my thrice-blest shoe

(White wings puffing up behind)
The distance there and back. I
Know this place! Haven't I been
Here before? A different country, true, but

EYES

I know those eyes. Imitation faces
Of the puppet-people gliding up and
Down the halls, somber pull-toys on a string.
Games room, TV lounge and kitchen,

Endless, endless up and down,
Back and forth,
Up and down, we're never through.
(*We're never through.*)



movement news

The International Mad Movement

By Anne Boldt and Della D. Nihera

Each year in North America, a group connected with the Psychiatric Inmates' Liberation or Mad Movement sponsors a conference. The Women Psychiatric Inmates Liberation Front organized the 12th Annual International Conference for Human Rights and Against Psychiatric Oppression. It happened in Pueblo Colorado in June, 1984.

Participants demonstrated at the state hospital and the prison, developed and attended workshops covering themes of psychiatry and the CIA, psychiatric genocide, racism, women's issues in the Mad Movement, a history and strategies of the movement, alternatives to psychiatric violence and deprofessionalizing care and support. The videos made available by conference organizers included "Fit to BE Untied" from Italy; "La Psychiatrie va Mourir" from Quebec; and "Frances" from the U.S.

At the public speak-out, former psychiatric inmates used the open mike to talk about our lives on the inside. Forced drugging, electroshock and leather restraints were frequently mentioned. Women spoke of the violence in our lives, a violence perpetuated in part by the "mental illness" industry.

The majority of women ex-inmates in the Mad Movement seemed to feel little solidarity with the U.S. feminist movement. As a whole, U.S. feminists have refused to take a position against the medicalization of undesirable behavior, electroshock, forced treatment or medical incarceration. It is not uncommon for a woman to land in a cage through the direct efforts of "sisters" and later for these same sisters to publish papers on the experience of "madness." Furthermore, since feminist therapy has reached the position of dogma and is now beyond community criticism, violence against us by feminist therapists is either silenced or considered ex-inmates' own faults.

Mad Women's victimization is encouraged when university-trained and therefore socially proclaimed experts attempt

to tell ex-inmate stories. Most feminist "experts" write their versions of our experiences using an incomplete feminist analysis rather than seeing us from the perspective of our Mad Movement. We think our survival problems as women are due in part to racist, classist and sexist ideologies about normality and also, because we are psychiatrically labeled, defined and tortured by women and men. "In their zeal to isolate the specifically sexist component of psychiatric 'treatment,' feminist critics have unwittingly ignored or continued other dehumanizing psychiatric practices." (Madness Network News, V.4 No.3 p.9)

Mad movement policies and priorities differ from state to state and country to country. When Swan, an ex-inmate activist, traveled around Europe she found that awareness of the international Mad Movement was on a very low level. Though every group knew of the oppressiveness of forced psychiatric intervention, a lot of people had no idea that other liberation groups existed outside of their countries. This amazed Swan because their publications all carried similar graphics, poetry, articles, and slogans: "The fun part about traveling around Europe was that I would go to Germany and they'd say, 'Wow! You mean there really is a movement in Holland!' and they'd be really excited about it."

The politics of various groups obviously influences the kind of alternatives they create or envision. In Germany, the SSK (Socialist Self-Help Cologne) has existed for about 10 years. Members are from all kinds of institutions. Their major goal is to create viable living/working communities within, and as an example to, the oppressive society. The SSK is a collective leftist group whose members recognize that adequate housing is essential to independent living. The non-hierarchical group has no professional or volunteer "help." Decisions are made during meetings which happen six days a week. The SSK has several houses and does not depend on the State for funding. While the collective fights against incarceration and established psychiatry, they also fix up old furniture, run a moving business, do interior decorating, paint, and do other jobs to keep them independent of the "mental illness" industry.

They've survived infiltration from government agents who deliberately tried to disrupt the SSK, and a libel suit from a local snake pit.

The Mad Movement is also active in Holland. The women's ex-inmate group call themselves "*De Helse Hex*" (Hell's Witches). The largest number of ex-inmates belong to the Clientenbond. Not all Dutch ex-inmates agree with the Clientenbond's reformist position but it is successful in organizing large groups to recognize psychiatric oppression and violence. The group does not want to scare people off with a radical approach to change. They believe that with their conservative approach of not rocking the boat too much, they can make friends with people in positions of power and push through some changes. They do not speak of closing down institutions and deprofessionalizing services, but of making them voluntary and more survivable. According to Swan, many of the most outspoken and radical activists in Holland are not ex-inmates.

In the past five years, the Mad Movement in England has grown in size and number of groups. Many of those involved are women ex-inmates who are forming support networks and organizing around psychiatric oppression. Many groups are trying to stop the so-called sudden deaths in England's institutions of incarceration. The explanation for these deaths is forced drug overdosing and abuse. At this time, the groups are unsure what direction they will take in their challenge to psychiatry. They consider the U.S. Mad Movement conservative while the U.S. thinks the same of them. Socialized medicine does change expectations and U.S. Madwomen have difficulty understanding this position.

PROMPT (promotion for the rights of mental patients) is a small radical group of ex-inmates in London. They are considered the fringe of the Mad Movement by both the left and other ex-inmate activists. PROMPT recently raised 200 pounds and offered this to any psychiatrist willing to undergo a series of shock treatments. Unlike psychiatric inmates, the psychiatrists would have truly informed consent since PROMPT listed all the effects of shock, from memory loss to brain hemorrhages. So far no psychia-

trist has taken up their offer. This group takes a stand against all psychiatric and psychological intervention and maintains that when a person can be treated against her will if she refuses voluntary intervention, than actual voluntary treatment is not possible.

So far, the international Mad Movement can organize around the issue of forced treatment but has not really what that means. While the Dutch and Danish women's movements are more supportive of the Mad Movement than U.S. feminists, there are still problems of unity between radical Mad Women and radical professionals.

At an international conference in Holland in December 1983, Swan attended a workshop on women and psychiatry. Since it was billed as an ex-inmate gathering, it surprised Swan that this workshop consisted of professional women who wanted to talk about their oppression as service providers. For years they had been struggling to allow incarcerated women to choose between a female or a male therapist. Swan asked about the inmates' right to choose no therapist. The professionals could not respond to this for such an idea was apparently beyond their frame of reference. Swan mentioned that this happens at most conferences where professionals and ex-inmates are struggling against oppression. The voice of the ex-inmate is silenced or ignored.

At the International Conferences for Human Rights and Against Psychiatric Oppression in North America, a situation like this probably will not happen in the near future because professionals are not invited unless they are also ex-inmates. We do not believe that when an industry depends on needy clients, that those getting paid want to see their payees involved in peer support and alternatives outside the "mental illness" bureaucracy. The issue of professionalization is a touchy one within the Mad Movement. We need, as a movement, to sort out the differences between voluntary/involuntary, cooperation/cooptation and between dialogue and control. No doubt these issues will surface again in 1985 at the 13th Annual International Conference for Human Rights and Against psychiatric Oppression in Quebec City.

The APA (American Psychiatric Association) Demonstration

After many months of planning, May 7, the day of psychiatric inmate liberation movement's demonstration against the APA, arrived. We started marching about 9 a.m., reaching the main entrance of LA Convention Hall where we held

our demonstration. We had timed our demonstration to coincide with the official opening of the APA convention. Our numbers were small—about 50—but the energy and excitement was high, exploding in speeches, chants, and song. Our main thrust was against forced treatment and the mind and body destroying "treatment" of psychiatry. At about 10:30 we began our march through downtown LA, to the Social Security Office where we handed out the statement on Homelessness from the 11th International Conference on Human Rights and Psychiatric Oppression. Our next stop was the Women's Center in downtown LA. Although we had planned to commend the Women's Center, we had learned recently that they didn't want anything to do with us and that they had a psychiatrist and psychiatric nurse on staff which they apparently used often. Rather then commend them as a refuge that helped destitute women without psychiatrizing them, we decided to read the women's statement from the 10th International Conference on Human Rights and Psychiatric Oppression. The Women's Center's response was anger, at one point screaming at us that we were disturbing the "mentally ill" women inside.

Finally, we arrived at City Hall. The tribunal that followed was exciting, with planned speeches, followed by an open mike, and singing, which opened and closed the tribunal. By 4 p.m. we were exhausted, but exhilarated. Some of us faced long drives back to northern California and others, more planning for events throughout the week. The days events, specifically the demonstration and march, were well covered by the media, with a story going out over the Associated Press (AP) wires.

The confrontation between the psychiatric inmates liberation movement and the APA was not over. Through negotiations between APA representatives and ex-psychiatric inmates, it had been arranged that there would be ex-inmate representation inside the APA convention through a forum, literature table, and a private meeting with the APA officials. We had been forbidden, however, to sell our literature, the official APA line being that money did not change hands over the display tables. On Tuesday, the day after the demonstration, some of us sold movement literature openly at our assigned table, risking possible arrest. We had decided to openly confront this hypocrisy which pretended that the APA and its annual meeting were not a mammoth commercial enterprise. Rather than being arrested, our table became a hub of activity, attracting lively discussion and curious on-lookers. One drug salesman brought one of his co-workers over to our table to show him that our graphics were "using our material against us".

Wednesday was the day scheduled for our private meeting with the APA brass and our forum. The forum, called "Former Psychiatric Inmates Look at Psychiatry," had been advertised in well-placed signs and in the daily APA newspaper published during the convention. The private meeting began sharply at 9 a.m. in the board room of the convention center. Representatives of the APA such as the outgoing and incoming chairmen of the Scientific Program Committee, the APA Medical Director and Vice President, and more, were in attendance. Clearly they were not happy to be there, but equally clearly they knew they had to be, that our time had come, and that we were a growing power that they needed to deal with. There were 10 of us, composed of northern and southern California ex-psychiatric inmates who wanted to attend. It was an historic meeting, for the simple reason that it occurred at all. Rather than deal with substantive issues, we set up a process for dialogue between the two factions in the future as well as for real participation by ex-psychiatric inmates in next year's and future APA conventions.

The forum was inspired. Although there had been almost no time to prepare, the six presenters were well organized, clear, and dramatic in their presentation of subjects which ranged from the horrendous history of the APA, to stigma to individual experiences to the destructiveness of the drugs and shock treatment, to the self-help movement and its alternatives to the dehumanizing present mental health system. Working together in unison, the six reached a spiritual high in their commitment to equality and justice for past, present, and future psychiatric inmates. The formal panel presentation was followed by an open mike, which a few psychiatrists used to debate the panelists. The forum was also well covered by the media, with a story in the *Los Angeles Times*, AP coverage, and even articles in the APA newspaper, *Psychiatric News*. coverage, and even articles in the APA newspaper, *Psychiatric News*.

It was now time to separate and say goodbye. It was an experience all of us would remember and cherish. It was an experience which had an impact on the world we have organized to radically change.

By Sally Zinman

(from NAPA Newsletter, Summer 1984)

INTERVIEWS WITH EX-PSYCHIATRIC INMATE WOMEN:

Highlights of the 12th Annual International Conference For Human Rights and Against Psychiatric Oppression

Note: Our thanks to Allen Markman, with "The Madness Network" of WBAI-FM in New York, for giving us permission to publish these excerpts.

Woman 1: We reject the concept of "mental illness". We're here also to demand an end to electroshock torture. It leaves people permanently hurt and wounded on the streets . . .

Woman 2: I just want to say that I'm proud to be a madwoman, and that I couldn't have survived any other way. Although I've been tortured with 17 shock treatments, with Prolixin, with lithium, with being mind-fucked in this society, at least I know my mind, and I know I have my mind, and I know I'm aware of my feelings. I don't think there's any other way to take power, to claim our lives back, than by claiming madness, because our madness is all around us. It's what we feel as a natural reaction to being oppressed. And there are so many of us who are oppressed in this society in so many ways. Look at how many people are alcoholics, drug addicts. Look at how many kids today are killing themselves. Suicide is the largest cause of death among people under 25. This society is not fit for human consumption. Sanity is not what I want . . . No matter how much grief it causes me to be socially ostracized, I know that I'm being real with who I am and what I feel. I'm not going to live out my life passively. I don't want the straitjacket. I've already been institutionalized and I'm not going to wear it on the outside.

Jeanne Dumont: I live in Ithaca, New York. I've been a school teacher there for the past ten years. I've been institutionalized against my will about eight times. I teach a health education course. During college years I started to think a lot about the medical system and how corrupt I felt it was, and how it took power away from people, and how it was an economic rip-off, and how people were denied their own healing powers by submitting to the medical system.

When I started to become more radical and more political, my mother got scared. She saw me get drugged up, she saw me screaming. She got very frightened. Who was this person? Where was her old cheerleader/student council president?

The institutions are just terrorizing. I didn't get any help in the institutions. The only thing that came close to help were the interactions I had with other so-called patients. My sixth institutionalization was at Hutchings State Hospital, New York. It was an amazing torture chamber. They did sensory deprivation. They decided that I liked to be stimulated too much by my surroundings, so they stripped my room. I had decorated my room, and they stripped it of everything, took away pens, pencils, and left me in my room 50 minutes of every hour, and let me out for ten minutes into a dayroom with the other people. Then they would put me back—and call that help.

In fact, I have the treatment plan here from that hospital. I managed to get it. And it says: "Miss Dumont's problems are that she's outspoken, she's argumentative, and she can see through the lies. You've got to be careful with her because if you don't tell her the truth she'll know it. She bites and she kicks." I did not have my right to refuse medication. I was just about to have a court hearing, and then they released me, which is often the case. If you're institutionalized, if you're able to go through the bureaucratic system and get some legal help, right about when you're about to get it, often they let you go. They don't want the thing to go into a court hearing.

The whole thing is a scam. Some people survive the system without being as tortured physically as others, but we all get mentally tortured there. Certain norms and attitudes are imposed on us. There's a lot of people behind it. It's not just the shrinks. The family feeds into it. Certain people who have power. It's really frightening.

Four years ago, I came in touch with this movement of ex-inmates by leafing through Cornell's law library, no less. They happened to have the *Madness Network News Reader* in there. I found some names and wrote away for the paper and started getting connected to people. I went to the conference in Cleveland. This was four years ago. It was such a source of strength to me. It was also confusing because I met so many who seemed so much longer than I was. I was on lithium at the time and feeling very inadequate having to use the drug, disliking it, feeling it numbed my brain, made me feel gray, and was wrecking my kidneys. And I came to the conference where there's a lot of people seeming real strong and together and organized and political.

It's difficult for any of us coming out of the system to get both the support we need and to look outside of ourselves and organize for change. But this is the only group I have become involved with politically that does both of these things for me, and that can actually provide some of the emotional support and help we need to stay out of the institutions. I'm really

grateful to be part of this.

Genevieve: I've been in the movement for only six months now. This is the first time I found some support about what I went through when I was a youngster. I was locked up from when I was 14 years old to when I was 20. My parents put me there. I was disturbing everybody because I was so shy. I was always writing and reading. I couldn't relate with people. I didn't believe in them because they were always telling me lies.

The women's issue is the biggest discovery I've made here at the conference. I've never been supported like that, even in the feminist movement. I have been a writer since I was eight years old. And 12 years later, after psychiatry, I am writing again. That's because I have been supported.

I hope psychiatry will die. It's going to die. It has to.

Barbara Wish: My name is Barbara Wish. I'm from Denver, Colorado. I'm here because I'm a survivor of incest and rape and beatings in my home from my family. And I'm here to protest the locking away, drugging, shock torture and silencing of women and children who are survivors of this kind of assault in psychiatric institutions that patriarchal psychiatry calls "hospitals." I'm here to say that women surviving from rape have a right to their rage. And you'll have to kill me to silence my rage! I don't want psychiatry to label and control my rage by calling it "rape syndrome," by victimizing me and all women over and over again, by assaulting me with their language of oppression. I want my language and myself and my body back.

I am privileged as a white woman. I know that I don't even comprehend what Chicano, Asian, native, black, all women of color go through as victims of this white, male oppression.

I am an alcoholic. Alcoholics and drug addicts are drugged by psychiatry and are addicted further by legally sanctioned drugs. What does that say about our government and our society when a person is trying to recover from addiction and is injected with sanctioned drugs in the name of treatment? I call it cruel and inhumane abuse and torture.

I'm a lesbian woman. I was locked up for being "latently homosexual." My male doctor assured me that I must be going through my homosexual stage, but that I was assuredly heterosexual and okay and normal and legal and fit to back to my nuclear family. I'm here to say that violence against lesbian women by psychiatry must be assaulted the way I and other lesbian women have been assaulted. We must fight back and demand our rights to define our own sexuality on our own terms.

I'm here to say that I celebrate my survival from assault at an early age. I celebrate my rage. I celebrate my anger. I

celebrate being a lesbian woman. I celebrate being an incest survivor. I celebrate my freedom from therapists, psychiatrists, and all mental health professionals today. I join with other ex-inmates to express our rage at what psychiatry has done and is doing to a large population that is hidden and ignored and not talked about.

Two-thirds of all mental patients are women. I celebrate today with my sister ex-inmates, and celebrate women's rage and women's anger and women's pain and women's determination to never again give up our lives and our souls and our bodies to the genocide of psychiatry.

People Against Psychiatric Oppression

People Against Psychiatric Oppression (PAPO) is a non-hierarchical group composed of ex-inmates, mental health workers (no psychiatrists), concerned citizens, and a legal aid attorney. We formed in Cincinnati, Ohio, in May 1983 and are opposed to forced and uniformed drugging, involuntary commitment, and all medical model forms of "treatment," including electroshock and psychosurgery.

In December 1983, PAPO picketed the use of shock "treatment" at Christ Hospital in Cincinnati. Later in the month we drew 80 people in the community to a panel discussion on the damaging effects of shock, which included personal testimonies by shock survivors. In March 1984, we protested the use of ECT by forming another picket line in front of a northern Kentucky hospital. These pickets were covered by all the major Cincinnati television stations and newspapers. In May, a major television station ran a series on electroshock during a prime time news show in which they presented the views of PAPO. We are currently in the process of editing our own documentary on shock to be shown on cable t.v. and of forming a speaker's bureau which would make itself available to speak to interested groups about the abuses of psychiatry.

PAPO has discovered a relatively easy method of contacting other psychiatric victims which we would like to pass along to other groups. By placing a small ad in the Miscellaneous column of the newspaper, simply asking that people who had had shock "treatment" to call a stated number (our local newspaper would not allow us to print the name of our organization since they claimed it would be "too controversial"), we received calls from over 60 people in the area who wanted to tell their stories. Some of whom later became involved in our group.

The philosophy underpinning our organization is that we believe the "mental health" system is an outgrowth of, and supported by, our political system. The sexism, racism, and classism of that system is reflected in both "diagnostic" and "treatment" policies. Furthermore, teaching us to blame ourselves for, and to individualize, personal problems prevents us from understanding how we are similarly oppressed by the inhumane political and "mental health" systems.

Mary K. Newman

On behalf of

**PEOPLE AGAINST PSYCHIATRIC
OPPRESSION**

12th Annual Conference Committee Denver, Colorado

The 12th International Conference on Human Rights and Psychiatric Oppression was held in Pueblo, Colorado, June 1-5, 1984 and was organized by the Women's Psychiatric Inmate Liberation Front (WPILF) in Denver. In most ways the conference was successful. We struggled together to look at political issues within our movement—racism, sexism, violence against women—which strengthens our movement's efforts to end psychiatric oppression wherever it occurs: psychiatric institutions, juvenile homes, schools, prisons, and in the family. Continuing to gather as (ex) psychiatric inmates is important in communicating about our common oppression. We had an exciting speak-out in one of Pueblo's city parks and then marched to Colorado State Hospital to hold a successful demonstration. Earlier in the day some of us picketed at Colorado's Maximum Security Prison.

However, we are now financially in a hole to the tune of \$2,500. We are writing this letter both to make an appeal for financial support and to talk about what our experience was like organizing the conference and our concerns about changing how the conference gets organized for the better. Talking with people who have organized this conference in the past, we seem to have a shared experience that it has been personally painful, hard, and a disruptive thing to do. We hope this letter will increase dialogue about how to change this experience.

WPILF has been working in Denver for about 9 months. The group was formed by 4 lesbian women initially to organize a demonstration in Denver for the International Day of Protest Against

Electroshock held Oct. 22, 1983. Soon after we had formed, we were contacted by Judi Chamberlin and Anne Boldt who said that other people who had expressed interest in taking on the organizing of the conference no longer felt able or "ready" to do so; we were asked if we would consider doing so. Although WPILF did not have a sense of the traditions and logistics of planning for this conference, we were willing to give it a try.

At the time we decided to take on conference organizing, even though there were only 4 members in our group, we felt we had a lot of dedication and energy to do the job and do it well. But things were happening to us personally and politically in town that made it difficult for a group of all women organizing to keep on target. From meeting to meeting we were all having such a hard time keeping ourselves alive and out of institutions—dealing with incest survival, recovery from addictions, rape, suicidal feelings—that it was difficult to keep on task with all the stuff that needed to come together to get the conference planned. We learned that in January or February we should have been confirming where the conference would be held, when in fact it wasn't until April that we even had found a place to hold the conference. Things got backed up.

In addition, organizing around psychiatric inmate issues in Denver was so new that we had a generally unreceptive and unresponsive press. Most demoralizing, where we did expect more support—from the women's community, the gay/lesbian community and the left—we received mostly contempt. We were not prepared for the incredible mentalism we ran into from these groups. The worst was our interaction with "Big Mama Rag" (BMR), a feminist news-journal that has been publishing out of Denver for the last 11 years and the Rape Awareness and Assistance Program (RAAP), a new "feminist" group organized to give support to women who have been raped that has been coopted by therapists and the police.

Members of the conference organizing committee had been involved in bringing the issue of psychiatric assault and oppression into the feminist press through BMR. We ended up taking on a lot of painful political fights over our own madness, suicidal feelings and our position that therapy was of no use to us. Our rage against psychiatric oppression and feminist therapy was seen as "inappropriate." BMR has ended up becoming inactive primarily over the politics of madness that was continually only viewed as problems of individual women. Our initial confrontation with RAAP was when women who were viewed as "not handling their rape properly,

too angry," were referred for psychiatric evaluation and institutionalization. Rape, incest, and battering survivors comprise a large portion of the women locked up in psychiatric institutions and yet in a meeting with RAAP, our experiences were discredited when they asked us to *prove* how many women have been locked up because of rape, incest, and battering. RAAP members were unwilling to take a stand against women being institutionalized because they are survivors of rape, incest, and battering. Furthermore, they were not even willing to acknowledge that rape occurs in those institutions all the time. This ideological battle amongst our best friends and lovers was happening as we were trying to organize the conference.

More general financial problems resulted from the fact that we did not know how much money it would take to organize a successful conference and underestimated the expense. We were interested to keep the cost as low as possible. For this reason we set the registration fee to exactly cover the cost of room and meals, in believing WPILF could raise the money to cover the cost of meeting rooms, publicity, mailings, and even generating T-shirts and bumper-stickers to raise money. However, fundraising turned out to be a lot more overwhelming and difficult to get support for than we had originally figured on.

Fewer people attended the conference than had been planned for, so that financial guarantees made to the U. of Southern Colorado for room and meal

charges were not met. We are not sure why this conference was lower in attendance than other conferences. Partly it was because information about the conference went out late due to the struggles already mentioned. Also we don't know but it is possible that some of the lower attendance had to do with sexism and homophobia within the movement.

These problems we ran into raise important questions in our movement's organizing efforts. There are certain problems that might not have happened, or could have been more easily controlled or fixed, had there been some way to pass information from one organizing committee to the next, about: budgeting, time schedule for mailing, cost of publicity, incorporating the conference, etc. WPILF is not incorporated so that the debt falls directly on the one member who signed her name. That person is potentially facing personal bankruptcy over this debt. This predicament should not have happened. This information should have been available before the fact, not after.

At the last general meeting of the 12th Annual Conference, there was a feeling people wanted more structure before and during future conferences. Some of

the bind WPILF found itself in was the result of a kind of "tyranny of structurelessness" in terms of conference organizing. We would like to encourage the use of our journals, "Phoenix Rising," "Madness Network News," and other group newsletters to share information about conference planning and people's personal experiences from the conference. Also we need to use these publications to talk about how we support people to stay out of institutions, how to survive an institutionalization, legal battles; etc. We hope that the bind we encountered will move our movement along towards change.

We are having a hard time in Denver offsetting our debt because two women who attended the conference ended up in psychiatric institutions and we have been working to get them out. We would really appreciate any support you can give us. Here is a tax free number, DN-0222680, to use with your donation, payable to "Twelfth Annual Conference Committee" at P.O. Box 61307, Denver, Colo. 80206. We also have bumper stickers and buttons for sale through the mail. Bumper stickers say, "Psychiatry is Social Control" or "Alcoholism Kills" for \$1.25 each. Button say, "Avoid Freud" for \$1.25 each. This cost includes mailing.

Thanks for your support. See you in Quebec City.

In Struggle,
Twelfth Annual
Conference Committee

Community Solutions To Sexual Violence: An Impersonal And Very Personal Reflection

By Bonnie Burstow

On May 11-13, 1984, an historic conference took place in Toronto, the first of its kind in North America. The conference was called "Toward Community Solutions to Sexual Violence." Prison abolitionists and feminists came

together to begin addressing the issue of sexual violence.

Up until now, the criminal justice system or, more accurately, the criminal injustice system could depend upon these two groups being divided. What brought them together was the realization that the system serves only itself. It imposes its authority and reinforces its power through imposition. Meanwhile, the victim of sexual violence receives no compensation and is further victimized by being dragged through a long and painful court process. If she gets scared and changes her mind about testifying, she is likely to be imprisoned. If she goes through with her testimony and loses, she must confront the risk of her attacker immediately retaliating. And, should she go through with the court process and win, she then lives in fear of what will happen

to her when the greatly embittered rapist is finally released. Correspondingly, the offender is victimized by having to spend years in a demeaning institution, an institution where he is treated badly even by fellow inmates, since sex offenders are regarded as the "lowest of the low."

It is with this awareness—this growing sense of unity—that the Quaker Committee on Jails and Justice decided to organize the conference, and feminist groups such as the Toronto Rape Crisis Centre participated. The conference featured three keynote speakers: Fay Honey Kopp, Lorene Clarke and Jeri Wine. Honey wrote the book on abolition (*Instead of Prisons: A Handbook for Abolitionists*). She provided a general overview, framed against the patriarchal context. She also discussed a variety of

community approaches which have been taken, including victim-offender reconciliation programs and consciousness-raising groups for offenders. Lorene, the second speaker, is author of *Rape: The Price of Coercive Sexuality*. She touched on many similar issues, while placing special emphasis on the inadequacy of laws pertaining to gang rape. Jeri Wine of OISE (Ontario Institute for Studies in Education), the third speaker, spoke chiefly about the victims. She expressed her concern that programs for offenders not occur at the expense of programs for victims. Like previous speakers, she raised the issue of pornography. Furthermore, she pointed out that most women have been sexually oppressed in some way by the time they reach adulthood.

The following day was devoted to workshops, which included: an overview and exploration of alternatives, with Honey; a discussion of self-help therapy groups for offenders, with Les Johnson; and an experimental workshop on incest, which I led.

The third day dealt with the question: "Where Do We Go From Here?" It began with evaluations and included some major criticisms. After the evaluations, the group proceeded to brainstorm. The major suggestions expressed were the following:

1. That a victim-offender reconciliation program be set up in Toronto.
2. That better services for incest victims be established. (Particular attention was paid to "buried incest victims"—people whose experiences happened long ago and who still had not been helped.)
3. That an anti-pornography campaign be started.
4. That consciousness-raising-groups for offenders be established.
5. That educational material and/or tools be created.
6. That representatives from this conference be sent to the Second International Conference on Prison Abolition.
7. That a coordinating committee to facilitate this work be established.

The coordinating committee was established within a few weeks after the conference. Since then, it has sent questionnaires to conference participants, asking them in which activities they would be interested to participate. The priorities seemed to be:

1. the anti-pornography campaign.
2. media work.
3. the creation of an education kit.
4. representation at the next International Conference on Prison Abolition.
5. a committee on incest.

A movement has been born. I have some very personal concerns, as well as joys, which I now would like to share. One of the joys was the presence of *Phoenix Rising* at the conference. Nira Fleischmann and Hugh Tapping had a

table in the main room, where they sold copies of *Phoenix Rising* and answered questions. As the conference drew to an end, a number of people came up to me with comments such as, "I never even heard of *Phoenix Rising* before. It's really terrific!" For me, this was a high.

A still more personal joy came from the strong concern about incest. As a therapist who specializes in incest, I am painfully aware of the inadequacies of our present resources for incest victims. Most therapists, my clients tell me, change the topic when they attempt to discuss their incest experiences. I also have been told of incest groups where the therapists are homophobic, and of still others where the therapist stirs up feelings and then refuses to deal with them.

The reality is that incest *does* happen to people, and it *cannot* simply be forgotten. I know this as a therapist. I know this because I myself am an incest victim. There are terrible things which happen to incest victims—things we repress, things we very much want to forget or make light of, but things we know we have to remember and take seriously. I remember thinking that I had been split apart, that I had been maimed for life. I remember wanting to see a doctor in the unlikely eventuality that I could be "mended" if I acted quickly enough, but at the same time realizing that I could not do so; that I could not even talk to anyone for fear of the consequences. I remember worrying about what 'he' would do to me next. I remember pain that felt like it would never end. I remember feeling some pleasure too, as well as the guilt that came with it. I remember losing consciousness on many occasions. Although I have worked through many of these dilemmas for myself, to this day I continue to get new memories; memories that need to come out. And, to this day, I often wake up in the middle of the night in a cold sweat.

I am not alone. Although we've been keeping it a secret for a long time, about one in three women is an incest victim, many from early childhood.

So where do we go from here? We work and work and work until a very different sort of society emerges. Personally, I look to the day when real help is available for all involved in incest and rape, however long ago the experiences may have taken place. I look to the day when the sexual integrity of others is respected, whatever their sex, age or sexual preference. And I look to the day when we all can claim back the night—yes, the night and the morning and the afternoon as well.

At the same time, I am not holding my breath waiting for a more humane and community-oriented approach to sex offenders. Our families and our family-oriented society have vested interest in maintaining the prevailing attitudes. The

reality is that the vast majority of sexual abuse occurs inside the family itself. We have not wanted to face this alarming fact. So intuitively, we have resorted to the oldest evasion tactic in the book—*scapegoating*. Give us a few scapegoats and the myth of the nurturing family remains intact.

Unless we are willing to stop scapegoating, and to examine what must be examined, isolated sex offenders will continue to be thrust into prison and treated inhumanely. Such people will continue emerging from these prisons as bigger and better rapists; children will continue to be molested by fathers, grandfathers, uncles, brothers, and God knows who else. And "mental hospitals" will continue to have an ample supply of allegedly "lying" or "deluded" women to drug, to shock, and to SILENCE.

The Hole In My Head

You asked me to
return to teaching.

You said that,
"the youth of today need
guidance."

You opened a hole in my head
and poured in
chlorpromazine, fluphenazine,
haldol, stelazine,
saying,
"these will help you
to help us."

The hole in my head
where my brain used to be
is now empty.

If I am to be
your insulin,
your salvation,
your apostle,
show me that
the system that drove me
insane
is prepared to look at
its own insanity.

by Al Todd

Women and Shock Treatment

by Paula Fine

Editorial Note: The following article originally appeared in *Issues In Radical Therapy* (2-9-11/Summer, 1974). Relevant yet, a decade later, it is here printed with the permission of Paula Fine and the IRT Collective. Our thanks to both.

"The most successful form of oppression has always been that in which the oppressed were conditioned to cooperate into their own oppression."¹

During the past two years I worked in a mental institution and my experience validated the above statement. As my awareness of the oppression of women heightened during these years, I took note of the way women were treated. During this time, I met many women who either sought psychiatric help or were coerced into getting "help." They were diagnosed as depressed, hysterical, psychotic, and schizophrenic. The majority of these women were treated with electric convulsive shock treatment (ECT).

Nine years ago when I first witnessed ECT, I wondered who could have invented such an inhumane and grotesque way of treating someone who was already frightened—frightened due to emotional disturbances. Now, years later, I've met and grown to care deeply for many of the people who have received this treatment. Many are women who have been oppressed for the majority of their lives. For them, treating them with electric shock was like adding another link to the chains they already wore.

Electroconvulsive treatment was introduced in 1938 by two Italian psychiatrists. Cerletti and Bini. Despite over thirty years of experimentation in this area, there is still no convincing rationale why ECT is used. Furthermore, there has been no consensual agreement on a theory of its mode of action. In 1960 Tournay and Riddell (psychiatrists) reviewed ECT literature and found little proof of significant lasting benefit obtained from ECT.²

Treatment-Induced Amnesia

Some theorists believe ECT works by creating a treatment-induced amnesia. One psychiatrist feels that the amnesiac action of ECT becomes a learned defense mechanism. People who receive ECT learn to banish future stressful experiences from their memory. My questions are: why is amnesia a desirable effect? Why would a doctor want this effect for his/her patient? Could the following be some reasons?

Our society has assigned the work of housework and childcare to women. The self-esteem of women has been based on how well they fulfill these tasks. Since a woman's worth is established by caring for others (and not herself) and encouraging the accomplishments of others (and not her own), it is not surprising that many women begin to question the worthiness of their own existence. They begin to wonder, "Is that all there is?" When this happens, isn't depression a likely emotion they would experience? Is this depression necessarily abnormal?

At some point in her life, a woman must relinquish her role as childbearer and childcarer. This has been referred to as the "empty nest stage." At this point she must decide whether to make some radical changes in her life (and society has provided little or no guidelines to help make these changes), or to continue to be alone with the possibility of increased feelings of dissatisfaction, hostility, bitterness, worthlessness and depression.

At this point many women decide to seek psychiatric help (or they are forced to seek it by their husband or family), yet the psychiatrists do not understand her dilemma. If more men would compare the "empty nest stage" with their own retirement and the feelings they have about it, maybe women would be better understood by male psychiatrists. In the psychiatrist's office, it is likely that a woman is once again faced with the traditional male supremacist point of view. How does the psychiatrist view the empty nest stage? Does s/he also feel that a woman's importance has diminished once a woman no longer bears or cares for children? Is this what s/he wants a woman to forget? Is the amnesia and confusion of shock to stop her from questioning and feeling?

In my work in the hospital I saw the tremendous frustration felt by women who experienced amnesia. Imagine what it is like not being able to remember a friend or relative's name; one becomes more confused and therefore more anxious. Prior to ECT most of the women I knew were unaware of the reasons for their depression; in fact, several

women vehemently denied ever being depressed. Afterwards they still didn't know why they were depressed, although, at this point, more of them would admit to feeling "down."

Jolted To Reality

A second theory about how ECT works is that the treatment gives the patient some sort of psychological jolt to bring him/her face to face with reality.³ However, if amnesia occurs, what is reality? And if people are unable to understand or feel their depression, how will they view this "shock"? As punishment? Many women I knew did view shock as punishment. Sylvia Plath in *The Bell Jar* describes her experience as follows:

Then something beat down and took hold of me and shook me like the end of the world. Whee-ee-ee-ee it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant. I wondered what terrible thing it was that I had done.⁴

The punishment hypothesis assumes guilt to be a central feature of illness treated effectively by ECT, and this is in agreement with the general clinical impression that endogenous depressives who often show strong guilt feelings, respond most favourably to ECT.⁵

One woman with whom I worked closely expressed these feelings regarding her electric shock treatments: "I don't know whether to view them as my salvation (she attempted suicide) or punishment (she was very religious). I feel so good when they put me to sleep, I forget all the voices, and feel like I never want to wake up. Yet I'm afraid I'll die during a treatment, and I don't know why I am being punished."

The Dangers

Like lobotomy damage, ECT damage must also be investigated. To do this we have to understand the consequences of shock on behaviour.⁶ A woman who is frightened, tearful, and depressed is given shock treatments (to shut her up? stop her complaints?). She then suffers the side effect of fear and not knowing what she's afraid of or why she's afraid. She may suffer through the unpleasant experience of confusion upon awakening from shock; not knowing who she is or where she is. She may suffer amnesia. Her speed, handwriting, concentration, coordination, and attention span all may be retarded. The electric shock increases fear and stress which in turn causes stress ulcers, renal disease, or resistance to therapy and loss of identity.⁷ We begin with a woman unsure of her identity and end up with this same

woman now unable to even feel or remember any identity.

I have seen people become so confused and regressed that treatments had to be stopped for a while. Patients would lose or misplace dentures and eyeglasses; they would walk into the wrong bedrooms; they would become incontinent of urine and feces; they would be unable to eat or walk by themselves. And all the while they would be told, "You are responsible for your getting well! Take more care in your personal hygiene"—and unbelievably—"Don't worry!"

James J. Strain, a psychiatrist, wrote: Even today, fantasy persists of being required to expose the body, of being attacked, wiped out, obliterated, of dying from electrocution, and of suffering permanent memory loss or impaired intellectual functioning. Therefore, a most important aspect of preparing a patient for therapy is to correct his/her fantasies in order to reduce anxiety and, in some cases, even get them to willingly accept treatment. It should be explained to the patient that in modified ECT they will not be alone or physically exposed, will rapidly be put to sleep, and will not *consciously* experience treatment.⁸

It is true that today shock is not as barbaric as in the beginning days of its use. Today the patients are put to sleep before the shock is administered and also given a muscle relaxant to prevent fractures. But, who is to say what one experiences *unconsciously*? And it seems to me that Dr. Strain as well as other therapists are dismissing or denying their patients' fear of anesthesia which may be experienced as a fear of dying. And for him to say there is no brain damage or intellectual impairment is to totally ignore existing data which proves that damage does occur.⁹

Socially Acceptable Behaviour

In Jacqui Schiff's book *All My Children*, one of her children describes shock this way:

That dreadful machine. The poor helped, helpless people. I cannot stand to see or know the devastation and the people who say "Yes, it helped," because they cannot stand the thought that all they went through was for nothing...¹⁰

Schiff believes that shock masks personal problems. It frightens people into acceptable behaviour patterns. Thus, when patients are again exposed to stress they will "crack up."

When I would ask the women I met about their life situation or about what they hoped to get out of shock, a typical response was: "I want to get better so I can do the things I *should* do—clean the

house, wash the clothes, make dinner for my husband, and be the wife and mother I should be." A common complaint of a husband admitting his wife to the hospital: "She's just not like herself, she won't do any of the things she's *suggested* to do. She's afraid to go out. She used to be so active with the children and the house."

I would suggest the possibility that these women were bored, tired, or just didn't like the chores (though most women flatly deny such feelings). Once when I suggested this to a woman, she actually jumped up from her chair and angrily (her first show of a strong emotion) told me that her *husband* wouldn't like what I was saying, and asked that I should please stop.

One woman told me that her doctor decided she should have shock treatments because her psychological tests showed she was very depressed. yet she didn't think she was "that depressed to need shock." Several women, seemingly feeling better after a few treatments, were released only to go back to the same anxiety-producing lifestyle from which they came. They were given a few suggestions on how to prevent getting depressed again, but if a person can't feel depression, how can she prevent it? Very few women were ever able to change their lifestyle once they returned home. The result was that they were seen again in a few months—depressed—and not knowing why.

There were all kinds of other things that I observed at the hospital which reinforced my impression that ECT and the whole hospital program revolved around the goal of encouraging traditional sex roles and socially desirable behaviour. Part of the treatment program included the assignment of sex stereotyped activities. For example, women were asked to cook so that they could get over their fear of household chores! When doctors asked women patients about marital problems, the emphasis usually was: "What kinds of things do you and your husband fight about that upset *him*?" The nurses, too, were deeply enmeshed in sex role behaviour. I can sympathize with them because all of their training and work experience has put them in subservient roles to mostly male doctors. Yet, at the same time I was depressed that they were resistant to my requests for reducing the number of sex stereotyped activities in the patients' programs.

In general, staff avoided any discussions which would tap sex role complaints. Because of this, discussions about marital problems were kept at a very superficial level. On the infrequent occasions when alternative lifestyle suggestions were made, there was a general lack of support for acting on these suggestions. At best, a list of clubs or volun-

teer organizations were offered. Women of 55 or 65 years of age need more support than this to change their lifestyles. But the support was not forthcoming. Could it be that many therapists become uncomfortable listening to depressed and frightened women who feel helpless and hopeless? And, could this discomfort, in part, come from knowledge of his/her part in maintaining oppressive sex roles for women?

One woman told me she was given no explanation of why ECT would relieve depression, even when she asked. Nothing was told to her about possible brain damage. Now, 22 treatments later and six months after hospitalization, she still has migraine headaches every day and stays at home in bed believing her husband will stop drinking. She feels disgusted and disappointed that shock didn't help her. Who is she disgusted with? Herself? Her doctor? Psychiatry? She meekly answered, "I don't know, but my doctor is on vacation now and he told me not to worry about it until he comes back."

Why It's Done

Many people are not helped by ECT. Though some are helped temporarily, this occurs with the risk of serious brain damage and psychological damage. So, the question arises: Why is ECT still a widely used treatment modality?

Dr. Robert Morgan suggests the following reasons in his paper on ECT.¹¹

- Professional investment—there is a natural reluctance to face the research data suggesting that their therapy (I call it treatment, not therapy) has been destructive (Besides, there is always someone saying the opposite.)
- Research (showing what a danger ECT represents) takes a long time to filter down to the action levels of treatment.
- ECT is used as punishment—hospital staffs make the most of the fear of ECT to motivate desired behaviour.
- ECT is used as retribution—those patients chosen for ECT were highest on a doctor-patient tension-level scale. Patients least liked were given ECT.
- ECT is used as suicide prevention—understaffed, underspaced hospitals still use ECT as a weapon in the ward. Hitting the patient over the head with the ECT club confuses them enough so that they forget to do away with themselves.
- ECT fits the medical model—the doctor has been taught to do *something*. Patients believe the myth that the doctor has magical power which can cure them.

Dr. John N. Rosen developed Direct Psychoanalytic Psychiatry. He treats patients without the use of drugs or shock, but with the love and understanding of the therapist, and hours and years of caring. In a plea to his fellow psychiatrists he says: "If you can't do the individual any good, at least do him no harm. This means avoiding shock treatments. It also means not using this helpless individual as an experimental subject."¹²

Who Gets ECT

In a study performed in 1973, in the Department of Psychiatry of the University of Rochester Medical Center it was found that 72 percent of the 276 patients who received ECT were women, while only 28 percent were men (3:1). Women in their thirties with an acute onset of symptoms suggesting paranoid or schizoaffective schizophrenia with prominent depressive complaints were likely to be selected for ECT at that hospital. There was no explanation given for the choice of so many more women than men to receive ECT.¹³ Once again, I suspect this is because more women seek psychiatric help, and because more women have never had or have lost their sense of identity.

Before I left the hospital, I checked the lists of people given shock treatments over the past six months. The doctor now in charge has been in charge for the past three years. Although he said all three years were recorded, I was only able to find the records of the past six months. The data is as follows:

July—10 people, 9 were women
Aug.—16 people, 14 women
Sept.—14 people, 13 women
Oct.—14 people, 10 women
Nov.—11 people, 7 women
Dec.—7 people, 5 women

Again could this be because more women than men seek psychiatric help?

Generally, treatments were given two or three times a week, though some patients only received them once a week. Several people were being treated with ECT over a period of years with occasional lapses due to severe confusion or cessation of symptoms. Many of the people receiving ECT walked around like robots or zombies.

The day before I left, a woman was admitted for depression. Her husband had attempted suicide five years ago and

threatened daily to do so again. She worked at a job that she hated and had difficulty with her daughter. She had been seen as an out-patient since July. She wasn't able to feel anger, although she said that pictures showed that her face was angry. Her expectations and her proposed treatment—Electric Shock! When I asked the doctor why he didn't treat the obvious with more reality testing, I was told that "women aren't ready to hear the truth."

One woman was afraid to tell anyone about her fears because she was afraid she would be called paranoid or crazy.

One woman was actually admitted for

One woman was actually admitted for hitting her husband. She had been physically abused by him and her father for years. Her treatment: Shock.

My experiences in talking with these women regarding their hospitalizations were similar to those Phyllis Chesler recorded in *Women and Madness*. Most women considered themselves crazy. Many were confused, humiliated, naive and fatalistic about their hospitalizations. Most dealt with brutality (physical or mental) by blaming themselves or minimizing it. After all they were the ones who were "sick"—weren't they.

Conclusions

Throughout this paper I have raised several questions—all of which I feel need to be answered. I believe they can only be answered through collective action by women from all over the country who will demand and achieve control over their own lives.

A review of my questions: Is ECT to shut a woman up? Stop her complaints? Why is amnesia a desired effect? What do the therapists want women to forget? Why aren't people given more information regarding ECT? Why aren't patients allowed to refuse ECT? How is depression cured by shock? How can women prevent depression if they're unaware of the reasons for their depression? Why does a woman have guilt, and why does her doctor feel she needs to be punished with a shock to rid herself of this guilt? What is the etiology of the illnesses treated with ECT? Why does ECT work? Does it? Could the origin of many psychiatric illnesses among men as well as women be the oppression and repression we experience? Why hasn't society provided women with alternative lifestyles?

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Editorial Note: The following article originally appeared in *Issues In Radical Therapy* (2-9-11/Summer, 1974). Relevant yet, a decade later, it is here printed with the permission of Paula Fine and the IRT Collective. Our thanks to both.

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